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HEALTH CARE FOR VETERANS IN RURAL AREAS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

NOVEMBER 15, 1989

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HEALTH CARE FOR VETERANS IN RURAL AREAS

WEDNESDAY, NOVEMBER 15, 1989

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 8:08 a.m., in room SR-418, Russell Senate Office Building, Hon. John D. Rockefeller (acting chairman of the committee) presiding.

Present: Senators Cranston, Rockefeller, Simpson, and Thurmond.

Also present: Senators Baucus and Daschle.

Senator DASCHLE. Senator Rockefeller has asked me to begin the hearing in his absence. He will be here momentarily.

Our distinguished Senator from South Carolina is here and is prepared to make a statement. In the interest of time—and this goes to the Secretary's schedule, as well as those of many Senators—we will call upon the Senator from South Carolina to begin his statement as he sees fit.

OPENING STATEMENT OF SENATOR THURMOND

Senator THURMOND. Thank you, Mr. Chairman.

Mr. Chairman, it is a pleasure to be here today to receive testimony involving health care for veterans who live in rural areas.

The quality of health care provided to the veterans of this country has been a matter of considerable discussion over the past couple of years. It continues to be a matter of great importance. This matter came into clear focus this past spring during discussion of the VA supplemental appropriations legislation.

As the committee charged with oversight of the delivery of health care to our veterans, we must ensure that the men and women who served this country are provided with the level of care they need and deserve.

For many years now the Department of Veterans Affairs has been ably providing for the needs of the veterans of this country. I am aware that from time to time some cases may have fallen through the cracks; however, on the whole the Department is doing a fine job in meeting the health-care challenges of the veterans of this Nation.

In a little over a month we will enter the decade of the 1990's. As this new decade begins, more than 7.7 million veterans will be in the over-65 age category and, accordingly, more of them will be relying on the VA for health care in the years ahead. We must work

together to ensure that the needs and challenges posed by this group and others continue to be met.

Mr. Chairman, we have an impressive group of witnesses before the committee today. I am particularly pleased that Dr. Francis Goldstein of the Dorn VA Medical Center in Columbia, SC, is appearing before the committee. Dr. Goldstein has rendered a very able service to the VA and the veterans of this country. He currently serves as associate chief of staff for ambulatory care.

Born in Paris, France, he later received his high school education in Princeton, NJ. He graduated from Rutgers University in 1975, and the Medical College of Pennsylvania in 1979. After completing his internship and residency he began work for the Department of Veterans Affairs in 1982.

Dr. Goldstein is currently responsible for clinical operations of the outpatient department of both the Dorn VA Medical Center and the Greenville, SC, Outpatient Clinic.

In addition to his hospital and clinic responsibilities, he serves as an assistant professor for medicine at the University of South Carolina School of Medicine. With Columbia in the center of the State and Greenville in the upper part of the State, both the medical center and outpatient clinic serve significant members of veterans from outlying rural areas.

Again, it is a pleasure to have both Dr. Goldstein and the other witnesses with us. I look forward to reviewing their testimony.

At this time I must leave to attend another meeting.

Mr. Chairman, I wish to thank you for your courtesy in allowing me to make this statement at this time.

Senator DASCHLE. Thank you, Senator Thurmond. We are delighted you could be here.

I call on the distinguished Senator from Montana for any comments that he would like to make.

Senator THURMOND. Mr. Chairman, would you allow me just one more minute to make another statement?

I am very pleased that we have the Secretary of the Department of Veterans Affairs with us today, Mr. Edward Derwinski. I have known him for many years. We have taken trips together and we have worked together in various capacities. Incidentally, he visited South Carolina last Friday. He was grand marshal in the veterans' parade. We had a very long, large parade there. And then he made an address at the veterans' hospital.

Mr. Secretary, I just want to thank you publicly. I have written a letter you probably haven't gotten yet, but I want to thank you again for coming to South Carolina and serving in such a fine way and encouraging the veterans there and letting the public know of your deep interest in our veterans.

Senator DASCHLE. Thank you, sir.

Senator Baucus.

OPENING STATEMENT OF SENATOR BAUCUS

Senator BAUCUS. Thank you, Mr. Chairman.

First, Mr. Chairman, I'd like to thank Senator Cranston, the chairman of the committee—who I understand will be here shortly. He agreed to hold this hearing at the request of the majority

leader and myself. We wrote the chairman a letter asking for this hearing. I'm very happy that we're having it.

Mr. Chairman, I know you are very interested in rural health. Senator Rockefeller, a member of this committee, is very interested in rural health. That's why we're holding this hearing, although it is much more specifically focused on rural health for our Nation's veterans.

I won't spend a lot of time talking about my home State of Montana this morning. We have here, instead, Mr. Ray Seerup, who will be a witness a little bit later on this morning. Ray is from Billings, MT. Ray is the true expert on rural health as it affects veterans' care in Montana because he drives a van all the way from Billings, MT, to Miles City. It's about 150 miles. Then he drives it back again. He does this virtually every day so that veterans from Billings, MT, get access back and forth between Billings and Miles City, MT.

Senator Thurmond mentioned that the Secretary was in South Carolina recently. Mr. Chairman, the Secretary was also in Montana recently. The Secretary very kindly flew out to Billings, MT, and he, too, rode in this van. He got a sense of what Ray does every day. The Secretary also came all the way from Billings to Miles City. We spent a day visiting the Miles City medical facility. I want to thank the Secretary very much for the time he took. I know that he now understands some of the sense of distance and space that we have in our part of the country and how important it is, therefore, that the rural health-care facilities be open and operate in our part of the country.

Mr. Chairman, I have a lot of faith in the Secretary. I think there are also a lot of well-intentioned bureaucrats and planners and analysts in Washington, DC. They are well intentioned, but they really don't understand the sense of space and distance. Year after year we have to fight to protect our air service in States like Montana and other Western States. We have to fight to keep our regular, small hospitals open. It is a big fight, and I know, Mr. Chairman, you understand that. You have worked very diligently on this issue.

Highway funding is another issue that affects us in the West. We are always trying to maintain rear guard action against the more popular States where people don't understand how important highways are to the Western United States. There are lots of issues like that.

We've had to fight, for example, to keep the Miles City medical facility open. It is a major fight. I know the Secretary understands that and is on our side.

Without that hospital, Mr. Chairman, eastern Montana veterans would have to travel to the next-closest facility in Fort Harrison, MT, which is 350 miles away. Or they'd have to go to Salt Lake City, which is 712 miles away.

Los Angeles, Mr. Chairman, is about 350 miles from Sacramento—the same distance as between Fort Harrison and Miles City, the two facilities in my State of Montana. But between LA and Sacramento there are nine Veterans' Administration hospitals. Nine. So if one of those California hospitals closes there are eight others nearby.

As I said, I'm glad the Secretary is here to hear about our problems. I know he'll work with me on legislation to give VA hospitals like Miles City and Fort Harrison protection.

I'd just like to give you another example, Mr. Chairman, of the sensitivity of this issue. Just 2 weeks ago I asked Montana veterans to write me and tell me what they thought about Veterans' Administration health care. I have received hundreds of letters over the last 2 weeks. One came from the son of a veteran. He wrote about his father, a veteran of World War I. His father had died a few years ago in his nineties. His father had enlisted with the Montana Battalion in 1917 and had gone into action with the first American troops into France. His father survived the war. He died after a long, proud life and lengthy stay in the Miles City Hospital.

The son now lives in Billings. He wrote that Miles City "was close enough that I could drive down there"—remember, it is 150 miles away—"and read to him for an afternoon 1 day a week." If his dad had been in Salt Lake or in Denver, that could not have happened.

Something like this just doesn't show up on the bottom line, Mr. Chairman, but it is important and I want to make sure that Montana veterans will continue to have their hospital in Miles City.

I have other issues I'd like to discuss this morning, but I'd like to get on with the hearing and hear from the Secretary.

One thing is certain: We need to guarantee to all veterans, including those in rural areas, that they can get the health care that they need.

Thank you very much.

Senator DASCHLE. Thank you very much, Senator Baucus. I want to compliment you in your persistence in making sure, as we consider health-care needs in rural America, that those veterans, in particular, are given the kind of attention that they deserve and certainly that this committee can provide in terms of both oversight and legislative involvement.

Senator Rockefeller is going to be here momentarily. He is actually stuck in a traffic jam and has just called from his car indicating that he'll be here within a couple of minutes. We'll proceed with the hearing. I'll call on the Secretary in just a moment.

OPENING STATEMENT OF SENATOR DASCHLE

I think as we begin, the only remarks that I would make would be that I think, as we consider health care affecting veterans today in rural America, there are three facts that are overpowering.

The first fact is that we don't have the personnel that we ought to have serving rural health needs in veterans hospitals. It is becoming incredibly difficult for us to recruit the kind of personnel we need. Both doctors and nurses are in short supply. As a result, we have got a critical problem with regard to providing health care to veterans across the board in all aspects of health-care delivery in our State.

Second, we have a lack of resources. It isn't uncommon to see a ward shut down any longer in South Dakota. It isn't uncommon to walk into a hospital and find personnel providing services that are not in their job description as a result of the lack of resources that

become pervasive as you walk through the hospital corridors in rural America today.

As a result of the lack of personnel and the lack of resources, we also have a lack of access. That lack of access is what concerns our people the most.

As I look to the health-care needs in South Dakota there is no difference any longer between what veterans receive and what people in other parts of rural America receive. That critical shortage is having a devastating impact on the attitude, as well as the confidence, of veterans who made decisions about health care many years ago—decisions with regard to health insurance, and decisions with regard to even where they live, at times. As a result, they are now very concerned about the future.

Their view is that rural hospitals in the Veterans' Administration could go the same as our farms and our small towns. For that, there is a grave concern.

And so I applaud the Secretary in this issue. I certainly applaud what the VA has done in the last couple of months as resources are being directed to meeting some of these needs, but we have a long way to go. The concern has never been higher. There has never been more unanimity among veterans' organizations about the need to address this issue more effectively.

If we are going to address it effectively, we need three things: We need doctors; we need resources; and we need, in some cases, much better management of the resources that are there.

There is evidence of the need for better management in Sioux Falls, SD. There is evidence of the need of better management as we look to the difficult challenges we face in making sure that veterans have the access that they must have to health care, whether it is in South Dakota, Montana, Iowa, or any of the rural States in our country today.

So I hope that this hearing will begin providing us with an opportunity to consider more carefully some of these needs and direct what limited resources we have to ensuring that we maximize the availability of those resources to where they can do us the most good.

Senator Matsunaga asked if I would express his regret with regard to his inability to be here. He wants to express his warm welcome to the Secretary and to Marjorie Quandt, who chaired the task force that led directly to improved rural health care for veterans in Hawaii's rural neighbor islands and the VA's decision to establish a full VA medical center in Hawaii.

Senator Matsunaga's prepared remarks will appear in the record, without objection.

[The prepared statement of Senator Matsunaga appears on p. 71.]

Senator DASCHLE. Mr. Secretary, I know you have a busy schedule and you have to leave shortly, but let me ask you to begin, if you would. And let me again reiterate Senator Rockefeller's deep regrets for not being here at this moment. He should be here momentarily. He wanted especially to express his apologies for not being here right at the beginning of the hearing. But, knowing of your schedule, he is very interested in making sure that we accommodate your schedule, so we will take your testimony at this time.

Please introduce those that are with you.

STATEMENT OF HON. EDWARD J. DERWINSKI, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY RAOUL CARROLL, GENERAL COUNSEL; DR. DANIEL WINSHIP, ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR; AND MARJORIE QUANDT, DIRECTOR, STRATEGIC PLANNING OFFICE OF THE VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION

Mr. DERWINSKI. I thank you, Senator.

I am accompanied by Mr. Raoul Carroll, our General Counsel; Dr. Daniel Winship; and Marjorie Quandt who, as you mentioned earlier, represents the Veterans' Health Services and Research Administration.

I have a brief prepared statement for the record, which I'd like to submit.

Senator DASCHLE. It will be inserted in the record immediately following your oral testimony.

Mr. DERWINSKI. It is a little bureaucratic and a little colder than I would normally use. I just submit that for the record and, if you will permit me, I will make a few general comments.

I am pleased that Senator Baucus is here, and I am pleased that he raised the issue of Miles City. I was there the latter part of August, I believe. The Senator joined me there. For me that was quite an education.

You have to understand, when you come into the VA you start hearing a lot of old stories, and one of the stories is always about Miles City. You really haven't been in the VA, in my judgment, until you understand Miles City. So I went out there, and I came away convinced that any plans that the VA has had in the past to close down or scale down Miles City were basically flawed and that it should not be done. I came away convinced that the very point the Senator made, which was the distance involved—to think that a veteran would have to travel 700 miles to Salt Lake City would be just absolutely unacceptable.

Therefore, as far as I am concerned, as long as I am aboard you are not going to have to worry about Miles City; Walla Walla; Prescott, AZ, where I visited; Fargo, ND; Hot Springs, SD. You don't have to worry about them. They are going to be there.

It may well be that there will be some fine tuning and some logical adjustments in the total delivery care package. I think that's inevitable as medicine improves and medicine adjusts. But the permanent role and the permanent service of the VA I think is something that is absolutely necessary.

I came away from my early travels as Secretary convinced that, were we to rebuild the VA today, or just build it today, the locations that we have probably wouldn't have been selected. But the fact is that where they are now they are performing a very useful service, including those in remote areas—and Miles City is a classic case. Martinsburg, WV, is another that is out there 90 miles from Washington but serving a large rural area. It is absolutely essential that we continue to maintain the services of those medical centers. I want to assure you we have no intention whatsoever of closing any of those medical centers. If there are any changes, they

will be fine tuning merely to take advantage of any practical developments in medical care.

The other point I'd like to make is in a very broad sense, if I may. My deputy, Tony Principi, and I have focused on one basic responsibility that we feel we have toward veterans—we believe that every veteran in the country should have equally good access to equally good medical care from the VA. That means we have to have a truly national coordinated effort. We'll be coming back to you (I'm assuming, now, you're going to have a well-deserved break soon) and when you come back after the first of the year we'll be asking for consideration of a commission to tell us where the VA should be in the next 15, 20, 30, and 40 years so we can have a totally coordinated, effective, national program.

We have to stress that availability of service to veterans in all parts of the country. The challenge, obviously, is much more difficult in eastern Montana and South Dakota and northern Arizona and parts of West Virginia and Oklahoma than it is in the Chicago area where we have four major medical centers or in southern California or in the San Francisco area where we have four within 40 miles of each other. Similar clusters exist in other urban areas. There we probably have more administrative flexibility. We have less when you have a remote site like Miles City and, therefore, we don't intend to change it.

I hope that clarifies any concerns that your constituents might have, Senator.

[The prepared statement of Secretary Derwinski appears on p. 89.]

[The prepared statement of Dr. Winship appears on p. 92.]

Senator BAUCUS. Thank you, Mr. Secretary.

Senator DASCHLE. Senator Baucus, do you have any questions?

Senator BAUCUS. No questions, just thanks. Mr. Secretary, as far as I am concerned, you should be the permanent Secretary of Veterans Affairs.

Mr. DERWINSKI. I'll remember that.

Senator BAUCUS. I'll remember it, too.

Mr. Secretary, on behalf of the Montana veterans and veterans in very isolated areas, we are very thankful for your recognition to the need of veterans' facilities in rural areas, and also your commitment to maintain those same medical facilities.

I asked you to come to Montana because I had a sense that once you were able to see the distance and sense the space it would make a big difference. That is what happened. I am very happy that it did happen.

One statistic that I like to use, which also illustrates the sense of distance and remoteness in the Miles City facility, is this: nationally, as I understand, 90 percent of veterans live within 100 miles of a veterans' hospital. That's the national statistic. In eastern Montana, 83 percent of veterans live beyond 100 miles. There is a lot of space and sagebrush and distance. Many veterans live a long way away. Again, I am happy that you are able to see that and sense that. We're very happy, Mr. Secretary. Frankly, on behalf of veterans we are very much relieved. Thank you very much.

OPENING STATEMENT OF SENATOR ROCKEFELLER

Senator ROCKEFELLER. Mr. Secretary, I owe you five apologies. As you heard, I was stuck in traffic on North Capitol Street. I sat for half an hour. I feel terrible because I am extremely honored that you, yourself, chose to come here. I extend to you my deepest apologies, as well as I do to Senator Baucus and to Senator Daschle and to the staff of the committee. That's simply the worst I've ever been held up in traffic. I didn't want it to happen, of all days, for a Polish Cabinet member.

Thank you all for being here so early. The reason for our early start this morning is Leach Walesa's address to a Joint Session of Congress scheduled to begin at 11 this morning. I know that many of my colleagues are planning to attend, so I hope we can have a serious and thoughtful hearing this morning while also staying within our time constraints.

I have long been interested in veterans' issues, including, of course, veterans' access to health care. I have served on this committee since coming to the Senate in 1985 and am pleased to Chair today's hearing at the chairman's request.

In addition to my duties on the Senate Veterans' Affairs Committee, I am privileged to be chairman of the Senate Finance Subcommittee on Medicare and Long Term Care and chairman of the Bipartisan Commission on Comprehensive Health Care—recently renamed the Pepper Commission. The Pepper Commission is charged with figuring out how to provide access to health care for all our citizens, especially those without health insurance, and how to meet the long-term care needs of all Americans. As the Commission looks into these important issues, it is crucial for us to recognize VA's role in the overall scheme of health care in this Nation and to take VA resources fully into account in crafting any proposed solutions.

The Department of Veterans Affairs operates the largest health-care system in the country and any evaluation of how to meet our Nation's vast health-care needs must include a careful examination of the VA system of health care. VA is a model of what can be done and also a case study for what problems may develop.

Accessible high quality health care for all people living in rural areas is a national concern, not just a concern for veterans. By focusing on the rural VA system, we are looking at one component of the overall rural health-care picture—an extremely important component.

I know that my colleagues here today share with me a belief that veterans living in rural areas should have equal access to health care. Veterans should not be forced to travel long distances in order to receive vital medical care. It's not fair, and in some instances, it could be life-threatening.

I look forward to the testimony of all our witnesses today. We will hear from the Secretary of Veterans Affairs and other VA Central Office officials about what VA has done, is doing, and plans to do.

We will also hear from Pat Hart, President of the National Rural Health Association, to find out what is happening in the

Nation as a whole on the issues of access and quality of health care in rural areas and also on how he sees VA fitting into the picture.

Next, VA field officials from various facilities from across the country will explain what they are doing in this area and what their needs are. Finally, veterans service organization officials from across the Nation will give us their evaluation of the situation.

In order to keep the hearing moving, the committee asks that all witnesses limit their statements to 5 minutes. Of course, written statements will be printed in the record in full. After each panel has completed their 5-minute statements, there will be time for questions from myself and other Senators. I look forward to hearing your views and your insights.

Mr. Secretary, let me just express to you my deep satisfaction in terms of your service and the fact that you are where you are. I think you know very well my feelings, because we have talked in my office and elsewhere about your leadership within the Department and now on the Cabinet.

You and I have talked before about the problem of recruitment and retention of health-care personnel. I'm absolutely stunned, for example, that specialty doctors who come out of medical school in high-paying specialties are now asking $150,000 for their first year, and the top dollar that your hospitals can pay—which is the largest hospital system in the world—is $132,000.

The VA medical care system is experiencing physician shortages and nursing shortages because of budget deficiencies.

The transportation problems are particularly acute in rural areas. We, in West Virginia, have people that have to go from Clarksburg up to Pittsburgh for medical services, and they can do that, in fact, because there is a bus that the VA hospital at Clarksburg provides for travel to Pittsburgh, but it is not a mandated service. The Clarksburg VA could be forced at anytime to cut that important service because of a budget deficiency.

The VA health-care system is having to provide vital services to many veterans who lack insurance and have nowhere else to go.

Again, I want to apologize to you and to say to you that I am proud of your service with the Veterans' Administration.

I don't have any other questions at this time because you have to leave at 8:30. I do have some questions for Dr. Winship and others.

I hope you will accept my apology for being late.

Mr. DERWINSKI. If we could keep this on such a high note we'd be back more often.

I thought you had immunity from traffic jams. I thought that was part of senatorial prerogative. I learned something this morning.

Actually, Senator Baucus and Senator Daschle touched on a couple of practical points which I know you are interested in, and that is this whole concept of availability of service to veterans in rural areas. I just made the point that we had no intention of closing and no intention of making major changes that in any way would diminish medical care at any of our hospital centers in the more rural areas. I visited quite a few and am scheduled in about 2 weeks, I believe, to visit Clarksburg, WV. I am convinced more than ever that to pursue the goal of excellent medical care available to all veterans in all parts of the country, locations such as

Fargo, ND; Miles City; Prescott, AZ—these kinds of locations must stay because they provide the availability and access the veteran deserves.

So I have taken a good, hard look at the VA in the 10 months I have been aboard. As you know, my background is a city slicker from Chicago. I looked at the wide open spaces and was quite impressed, but I was impressed more by the fact that those veterans have to travel hundreds of miles to reach a facility. My constituents in Chicago, when I represented them, had a choice of three VA hospitals that were exactly 6 miles apart. That really isn't a travel problem. We could consolidate services there, specialize in services, and all it means to the veteran is that he or she has to travel 6 miles in a somewhat different direction.

If we close down Miles City, a veteran might have to travel an extra 400 miles to Salt Lake City. That is just not fair, and we won't allow it.

Having said that, I think you'll be impressed with our panel here. This is the first appearance of Mr. Carroll, our General Counsel, since he has been confirmed. Dr. Winship and Ms. Quandt you know well. They are all doing a good job. We think we have a good team. We think we are moving ahead in a progressive and practical fashion, despite budget headaches. And budget headaches are not an excuse or a cop out; they are here to stay and we are going to do our best to innovate and manage within budget constraints, and every possible savings that we achieve anywhere along the line we intend to plow back into medical care.

For example, we have consolidated our medical regions from seven to four. In total that will be a savings of $3 to $4 million a year. Three or four million dollars doesn't seem like that much money in Washington, but it is money that is going to go to medical care. Part of the savings will come from abolishing medical districts that we felt were an unnecessary, superfluous layer of bureaucracy. The people who had been employed there will primarily be located in hospitals.

So we are trying to do everything we can within our flexibility to improve medical care. That's where our challenge is, and we're just going to emphasize that.

I thank you for your courtesy and am open to any questions. If there aren't any, I'll turn this panel over to you.

Senator ROCKEFELLER. OK. It is my understanding, Mr. Secretary, that you had to go at 8:30.

Mr. DERWINSKI. Yes.

Senator ROCKEFELLER. I just want to give you that opportunity before we go on to Doctor Winship.

Mr. DERWINSKI. I'll be back later, of course, for the joint session.

Senator ROCKEFELLER. Right. I figured you might be there.

Mr. DERWINSKI. But I did want to kick off this hearing, and I especially wanted to thank you for your special interest in this subject. I also thank Senator Baucus and Senator Daschle.

Senator ROCKEFELLER. Well, it was Senator Baucus and Senator Daschle who were motivating forces behind getting this session going. Thank you very, very much Ed.

Mr. DERWINSKI. Thank you.

Senator DASCHLE. Mr. Chairman?

Senator ROCKEFELLER. Yes, Tom.

Senator DASCHLE. Are each of the members going to be presenting testimony or are they open for questions now?

Senator ROCKEFELLER. They have not presented yet?

Senator DASCHLE. No, they have not.

Senator ROCKEFELLER. They're open for questions. Please go ahead.

Senator DASCHLE. I would ask any one of the panel members—I know that the Secretary had to leave—inside publications reported last month that 20,000 VA patients a week are turned away from VA hospitals. We have an aggravated problem in South Dakota in that regard. Many of them are category B and C. Many of them, for various reasons, are turned away, in part because services cannot be provided at the VA hospital due to what I said at the beginning—a lack of access, in large measure, because of lack of physicians and lack of resources.

First of all I'd like to ask if you share that assessment. Is it about 20,000 veterans a week? Second, to what do you attribute that horrendous statistic if that is the case?

Dr. WINSHIP. Senator Daschle, I do not believe that we have data which would support 20,000 a week. Each time that we have had a look at that to try to determine, on a sampling basis, how many veterans we are really turning away it is considerably less than that. But I think that begs the question, because I believe that we, in fact, are not providing care for a large number of category B and C patients for which we previously did provide care.

The Secretary made the decision in fiscal year 1989 because of very severe budgetary difficulties. We knew we would be able to cut our expenditures by not caring for those patients that we were not mandated by law to care for, and that includes, in fact, the category B and C patients. So 1989 saw us take some very major steps, in fact, to bolster our delivery of care to category A patients who we are mandated by law to care for, to take a number of steps which would make access to care for those category A patients more equitable throughout the country, and that would be at the expense of some category B and C patients.

The reason I question the 20,000 now is because I believe that a lot of those category B and C patients—particulary category C—know that when they come to the VA they are probably not going to get care and so they don't come, and therefore don't get turned away. But that doesn't mean that the need isn't there.

Senator DASCHLE. There are many opportunities in rural America for B's and C's to get care that they may not be getting in the urban hospitals, and yet there is a lot of confusion about eligibility of B's and C's today. What may be the minimum level of access for B's and C's in one hospital is totally different than that of another. How do you hope to address this confusion? How can we ensure much better access for all veterans as a result of the confusion in the near future? Are you contemplating any change in your regulations with regard to access for B's and C's?

Dr. WINSHIP. The initiative that we are taking toward access is to ensure that we actually do care for those patients or those veterans that we are mandated by law to care for, and that is the category A patients. Now, the law really has not changed regarding

our care for category B and C patients, and that is that if we have resources available then we may take care of those patients. That's the language of the law.

Senator DASCHLE. Dr. Winship, if I could just—go ahead.

Dr. WINSHIP. The problem we have—and this really didn't begin in fiscal year 1989 but we recognized it in fiscal year 1989 and I think it continues into fiscal year 1990—is that the demand for care throughout the country now by category A patients is so great that the work load we are able to deliver can virtually be consumed by the category A patients alone. That means that we have been unable then, because of fiscal restraints, to make any kind of move that will expand our care for category B and C patients.

Now, in some of the rural areas—we were just talking about Nebraska, for example, on the way over—we do find that the capacity for care of more B and C patients is there and, in fact, no B and C patients are being turned away, or very few—or maybe no B's, but some of the C's. That's not true in many of the other areas. Our move toward attempting to develop true equity of access throughout the country is really based not so much on turning away B's and C's as a motive but to be certain that we care for our category A patients.

Senator DASCHLE. I'll just end with this, Mr. Chairman: I think we've come a long way in 5 or 6 years when A's, B's, and C's, all entered a hospital with the expectation they were going to receive care. Now, 5 years later, only those who are service connected have a right to expect care. In many cases they aren't even getting it as a result of the lack of physicians, the lack of resources, and the lack of adequate budget to ensure that their needs are being met.

I would hope that the additional amount that VA was given in the supplemental and the additional amount that they now have been given in the budget for the next fiscal year would afford us the opportunity not only to provide As—that is, service-connected veterans—with the care that they should have, but all veterans who have made health-care decisions 10 or 20 years ago—decisions about their future in health care—that effect their eligibility for receiving health care today.

There are veterans today in South Dakota who are not getting health care simply because they have been shut out of the VA's system and they've been shut out by health-care delivery alternatives because of their age or because of their health, and that's not right.

We made a decision retroactively affecting these veterans that is just a disaster for a lot of these veterans. I would hope that if you don't have the resources that, given the leadership I strongly commend in Secretary Derwinski and his willingness to come to talk to us about the problems the VA has, you'll come and show that leadership and demonstrate to us what real commitment we have to make in resources to meet the needs of veterans in rural hospitals, and that we do it as we prepare for the next fiscal year.

Dr. WINSHIP. Yes, sir. Thank you for that comment. We're sure game to do that and will do it.

[Subsequently, the Department of Veterans Affairs furnished the information which appears on p. 103.]

Senator ROCKEFELLER. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Dr. Winship, just a couple of points here. Number one, I think veterans get bounced about more than any other segment in society by the Government, and it is a real problem for both those in the service and those not on active duty.

I travel about military bases, and particularly in Montana. I see how Federal DOD decisions and, frankly, decisions made by the President and the Congress, as Senator Daschle has pointed out, retroactively affect our men and women in the service. It causes a very great problem with morale as various facilities and benefits are taken away that they planned on and counted on when they signed up for the service. The same is true with veterans.

I urge all of us to go the extra mile to prevent retroactive decisions that upset veterans' earlier plans in many, many areas. One certainly is health care and health-care benefits. I think Government has gone too far and been a little bit cavalier, frankly, in how it is treating men and women who have made earlier decisions and earlier plans and who have relied upon earlier commitments that this Government has made.

The second point is a bit more specific. I wonder if the VA could get to this committee data showing the numbers of A's, B's, and C's who have been turned away depending on whether the facility is in a rural or an urban area—particularly with reference to Miles City and Fort Harrison, MT. Could you compare the A's, B's, and C's that are rejected—particularly B's and C's that have been turned away at Miles City and Fort Harrison—compared with the national average, and certainly compared with an average urban hospital. That would be very helpful to me.

Dr. WINSHIP. We certainly can provide that in answer to your second point.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Veterans Affairs does not maintain data reflecting the number of A's, B's, and C's that are rejected. Rather we have statistics showing the number of applications for medical care that are denied due to lack of resources. For example, comparing two rural facilities, Miles City and Fort Harrison with one of our urban hospitals, the Bronx, we find:

Facility	Total number of applications	Treatment modality not available	Treatment modality percent of total	Care denied due to lack of resources
Fort Harrison	6,246	1	.000	11
Miles City	4,533	7	.001	0
Bronx	36,743	5	.000	0

Dr. WINSHIP. In answer to your first point, Senator Baucus, I certainly agree with you that disenfranchisement has been going on for quite a while. I think there probably is no single complaint that I, in my office and operations, hear more than the complaint that I, as a veteran, did have medical care. Then I either went somewhere else or some circumstances changed and I no longer have medical care and I don't understand that. We have that a lot.

Senator BAUCUS. And it is a justifiable complaint.

Dr. WINSHIP. It is a justifiable complaint. Yes, it certainly is.

Senator BAUCUS. Thank you.

Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Baucus.

Dr. Winship, let me just say that in the matter of rural health, obviously the main problem is access. Senator Baucus and I serve on something called the Bipartisan Commission on Comprehensive Health Care, and we're looking particularly at the question of 37 million Americans that have no health insurance at all, as well as the issue of long-term health care—for all Americans. Our goals are to provide solutions and hopefully legislation that will provide universal access for all Americans. Our recommendations, obviously, are going to be gigantic in their consequences.

In any event, we can't possibly do this work without taking into account the veterans' system. The VA system is the largest hospital system in the world, as I indicated earlier. We, therefore, have to work with you as we develop our recommendations because the VA is a very large component of overall U.S. health system.

It is inconceivable to me that veterans living in rural areas are not able to have access to health care. But that does, as we know, happen. I don't happen to think that veterans should have to travel long distances to get necessary health care. The question of beneficiary travel is controversial with some in this Congress who say that a veteran can fork out the money to get from Charleston, WV, to somewhere else if he needs a certain kind of health care. Well, beneficiary travel with some of us, including Senator Mitchell, is sacrosanct. It has got to be there. And yet it costs money, and veterans' hospitals and the veterans' system don't necessarily have that kind of money.

In any event, I just want to say that as we do our work on developing recommendation for comprehensive health insurance for all Americans, as well as long-term care for all Americans, working with the Veterans' Administration is a top priority. We can't do our job well without you because of the size and scope of what you do.

The veterans' hospital system, it seems to me, is an example of everything that can be, and yet also an example of so many of the problems that come up. We have to be realistic and honor where it succeeds and to be critical where it does not.

There is a particular question I want to ask you which may point—and particularly with the General Counsel here—to a certain kind of solution. The committee has heard a variety of concerns that some non-service-connected veterans who live in rural areas and who earn less than the cutoff for entitlement to VA care under category A—and that amount would be $19,759 for a veteran with one dependent—and who have some unencumbered land or equipment such as a tractor, are denied category A entitlement because of those unencumbered assets when they are valued at more than $40,000. Now, this is getting at rural health-care reality.

What is the current net worth limitation for health-care entitlement purposes and how is this figured?

Dr. WINSHIP. The statement that you make about the unencumbered land worth $40,000 or more is correct.

Ms. Quandt, could you give specific information about the calculation of that?

Ms. QUANDT. That is correct. But at any time when that value exceeds that the hospital must go to the Department of Veterans Affairs Veterans Benefits Administration (VBA) and ask on a case-by-case basis to have that reviewed. It will be reviewed based upon land value at the time and income at the time, and VBA makes that determination for us and turns it back to us. If they feel that in that situation the person is above a category A, we then are required to follow it. However, there are some variations during a year.

Let's say an individual such as that had come to us as a category A and something about his land had increased the value during that year. We will carry that patient until there is another application or at the end of that fiscal year. That value is again reviewed for us by the VBA.

Senator ROCKEFELLER. What I'm trying to figure is: In the intervening time, while this case-by-case analysis is being made, it would be my guess that the veteran isn't getting any health care. That's what is concerning me. Therefore, a question I would ask of any of you would be: Would the Veterans' Administration favor some changes in the net worth limitations for health-care eligibility for farmers or ranchers whose assets cannot easily be converted to cash? Is this a possibility?

Mr. CARROLL. Mr. Chairman, what I'd like to do, if I can, is submit that answer at some future time. But what I would like to emphasize is that while that consideration is being made at the regional office, the Department of Veterans Affairs does have substantial flexibility delegated to those regional directors. So the present income category I don't think is the inhibiting factor that maybe it is perceived as in many respects because the Secretary delegated to regional directors substantial flexibility to look at other considerations.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The $50,000 figure was set in 1989, in response to congressional intentions of establishing a figure that would be low enough to accommodate the provisions of care to the poor, non-service-connected veteran, while at the same time, restraining any dramatic increase in workload on the Veterans Benefits Administration.

Veterans Health Services and Research Administration (VHS&RA) is one in favor of any special dispensation for one segment of the economy over another. Experience dictates that when special treatment is offered to one segment, a precedent is established, which opens the door for other special interest groups, resulting in a further exacerbation of the limiting of care to category B and C veterans in favor of providing care to the special interest groups.

Senator ROCKEFELLER. Let's set flexibility aside. For the urban veteran, the house is exempted. For the rural veteran, the tractor equals, for his purposes of living, the house. It is not exempted. Why can't we extend this exemption on more than a case-by-case basis? It would seem to me that in your case-by-case basis you are probably coming down to the decision that the veteran can get the health care, but during all this analysis he's not getting it.

Dr. WINSHIP. Let me interrupt right there. If the veteran is in immediate need of health care, the veteran will get health care. If the veteran——

Senator ROCKEFELLER. And that is determined how, Dr. Winship?

Dr. WINSHIP. That's determined by the clinical status of the patient—the clinical situation as the patient presents. If that patient needs health care right now if it is an urgent situation, that patient will get health care.

Senator ROCKEFELLER. And will transportation from the rural area to the clinical decisionmaker be provided?

Dr. WINSHIP. Not necessarily. But at the medical center the patient will get health care.

Now, if the patient presents—and this becomes a clinical decision. If a patient presents for long-term problems and wants to be a member of the patient cadre of this hospital and is not in immediate need of health care, then they probably will not get health care until that decision is made. But that's some of the flexibility that we are talking about, and that will vary somewhat, I think.

But I think the point is that urgent need for health care will be provided and then questions asked about eligibility later. That's pretty much standard.

Senator ROCKEFELLER. I think the followup question here is the matter that I brought up before, and that is distance. If the veteran can't get there, then there is no clinical analysis and then there is no decision. If the veteran can't get there, then there is no health care given.

Dr. WINSHIP. If the veteran fits eligibility that is currently in place for beneficiary travel, he or she will get there. If not, then he or she will be on their own to get to the medical center. That's correct.

Senator ROCKEFELLER. But how does the veteran in the rural area know whether or not he or she fits that criteria of beneficiary travel?

Dr. WINSHIP. I think that person doesn't know that, and I think this is one of the conundrums that we deal with on a regular basis.

Senator ROCKEFELLER. So beneficiary travel is really at the root of access to health care for veterans in rural areas by any definition, is it not?

Dr. WINSHIP. No, I would not agree that it is at the root. I think it is not the fundamental problem about whether or not we can deliver health care. In some specific circumstances it may be fundamental to whether the patient can get to the medical center, but in the overall picture I think there is a much more important and basic kind of consideration as to whether we simply have the resources to take that patient as a patient.

Senator ROCKEFELLER. Senator Daschle?

Senator DASCHLE. Mr. Chairman, I don't want to interrupt your train of thought, but I would like to ask Dr. Winship a couple of questions after you finish.

Senator ROCKEFELLER. I'm through.

Senator DASCHLE. Dr. Winship, I've got to tell you that just isn't true. If you're saying that any veteran, regardless of category, who walks in and really needs health care is going to get it—is that what you're saying?

Dr. WINSHIP. Yes.

Senator DASCHLE. That is not true.

Dr. WINSHIP. Let me——

Senator DASCHLE. There are three hospitals in South Dakota, and I can give you the names—I can even give you some of the veterans who have died who have walked in and needed health care and have not gotten it simply because they were turned away because they were either a B or a C lacking the service-connected disability. They are not getting health care today. That is wrong.

Dr. WINSHIP. Let me clarify my point and then I would like to ask you a question in return. My point is that if a patient comes in who immediately needs very urgent care, our policy is that the patient will be cared for.

Senator DASCHLE. Well then your policy is not being carried out.

Dr. WINSHIP. My question to you is that if you know of such patients and can give me names of those patients I would like to have those, because I would like to follow up on that.

Senator DASCHLE. That's the point, Mr. Chairman. The policy is such that it is confusing, it is not being followed in many cases—and for good reason. In some cases there are no doctors. There are no resources to provide this care. But that ought to be a factor as we consider the budget. What are the resources we need to ensure that--and with every good intent Dr. Winship is saying this ought to be the VA policy as carried out. It is not being carried out in rural America today. There are veterans being turned away who are either getting sicker or are dying as a result of those rejections and that's wrong. We've got to change it.

I have mentioned earlier management. Our hospitals were given additional money in South Dakota. Do you know what they did with $40,000 in Sioux Falls? They didn't go out and find another doctor. They didn't go out and find more resources. They built, for God's sake, a revolving door. They spent $40,000 to build a revolving door with the new money they got. I can't tell you how damaging that was to the credibility of the VA in Sioux Falls, SD—and it ought to be damaging. That kind of decisionmaking is the kind of ridiculous attitude expressed at the local level—not with current level management of the VA at your level. As I said in the past, I have been impressed since Secretary Derwinski has taken over. But that kind of thing has to stop.

You've got a shortage of VA personnel—patients who need care, in some cases getting sicker. What do we do when they get additional money which they say they need? They go and build a revolving door to replace a door that has been in the hospital facility for many years.

Dr. WINSHIP. Well, you raise an important principle that I'd like to comment on. I can't comment on the revolving door, specifically, but I think that we must, if we are going to provide health care of high quality to our patients, be able to maintain our hospitals. That may well fall into the category of maintenance of the hospitals. We cannot let our hospitals fall down around our ears and say that the reason we're doing that is because we have to treat more patients when, in fact, we will be unable to treat our patients at all if our hospitals have fallen down around our ears.

I don't want to argue that particular point, but I think the principle is one that simply must be stated.

We have, for the last several years, taken enormous amounts of money from our maintenance accounts, from our capital accounts,

and you can go to our medical centers and you can see that. That's going to have to change, as well. If we're going to be able to provide the care that you want for the patients, that we want for the patients, and that the local medical center wants for the patients, we're going to have to have facilities that can adequately do that. So equipment accounts, maintenance accounts, nonrecurring maintenance, construction, and so forth, simply have to be preserved and some flexibility has to be—some judgment has to be used, obviously, and flexibility has to be used in that.

But I certainly agree with your point. I can't deny and argue with your point that you're making at all.

Senator DASCHLE. I just think the maintenance of a veterans' health is more important than the maintenance of a veterans' building. That's what we're talking about as we consider very limited priorities.

Thank you, Mr. Chairman.

Senator ROCKEFELLER. Let me make one additional point on the matter that I brought up earlier and has been referred to by other Senators as the unavailability of medical professionals.

One of the things that profoundly disturbs me in American medical life these days is that students who are going into medical school and going through medical school are going into specialties which we need in this country but which are being rewarded financially at levels which bear no relationship to their relative importance.

Primary care has to be reimbursed not only under medicare, but generally across our country, at a much higher level than is currently the case so that young doctors who are trying to pick a career will get much more into that kind of care.

Thus, a bill that I've been working on now for about a year called Physician Payment Reform, and which I think we will pass this session of Congress, will accomplish that. It will enormously increase—particularly, Senator Daschle and Senator Baucus, for rural areas—how primary care physicians are being reimbursed. In fact, in some cases there will be a 50 percent to 100 percent increase in how they are being reimbursed under medicare. Other aspects of the health-care system follow medicare—almost always.

At the same time, specialties will be coming down, though they'll still be higher than family practice. They will be coming down which will, in turn, make the veterans' hospitals more able to afford to get them to come. You won't have this situation where you can pay them $132,000, but they are demanding $150,000 because that's what they can get elsewhere. You will not have that problem, which is a linkage, as I see it, between what we can do on general health care in this country and the veterans' health-care system, in particular.

My final point is that I hope that one of the three of you will follow up and see if there isn't some way that we can solve this unencumbered land and equipment problem for rural veterans, so we do not have to go through them case-by-case but allow for an exemption. I hope we can make some kind of an administrative change. If we can do that, I think we'd get them into veterans' hospitals much more quickly. I would simply ask that you would respond in writing and see if an adjustment can be made.

Dr. WINSHIP. We certainly continue to wrestle with that whole issue. No one wrestles with that more than the people at the medical centers who have to deal with it. We will be happy to continue to work with that and work with you.

Senator ROCKEFELLER. Would you agree to have the answer to my question to us by the middle of December?

Dr. WINSHIP. Yes.

Senator ROCKEFELLER. Thank you. Please go ahead.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

For purposes of clarification, Veterans Health Services and Research Administration (VHS&R) does not have a net-worth limitation for health care entitlement purposes. What VHS&RA does utilize is a $50,000 trigger point for referral of net-worth determinations to the Veterans Benefits Administration (VBA). If a veteran has category A or category B income plus assets of less than $50,000, then VHS&RA does not refer the case to VBA. If the assets and income exceed $50,000, then the case is referred to VBA for a net-worth determination. This is done to ensure that net-worth is determined in the manner required by the Means Test legislation. Veterans are placed into category C based on income alone.

Dr. WINSHIP. The other comment has to do with our participation in the planning for the care of the uninsured, which you mentioned a few moments ago. We certainly would be pleased to participate in that effort. We believe that in addition to that we have a number of initiatives that we have done in rural health care, a number of things that we have done, some experience in that area that can be very helpful to the country.

Senator ROCKEFELLER. Well, I guarantee you that by March 1, 1990, the Pepper Commission—which I Chair and on which Senator Baucus sits—will issue recommentations for universal access to health care for all Americans.

I thank all three of you very much and would ask for that answer by December 15.

Generally I'd ask panelists for answers to questions that have been asked by December 1. That would be helpful. The particular question that I have asked you takes some decisionmaking within the VA, so I'd like you to have an additional 2 weeks for that. Generally speaking, questions should be answered by December 1 and submitted to this committee in written form.

Dr. WINSHIP. Thank you.

Senator ROCKEFELLER. I thank you very much.

The next person we will hear from is Mr. Patrick Hart. He is president of the National Rural Health Association. We welcome his testimony.

I want to ask Senator Daschle or Senator Baucus a question—we're all on the Finance Committee. We have VRA markup at 9:15. I think it is only going to take about 10 minutes.

Senator Daschle, are you going to be able to stay?

Senator BAUCUS. I've got that markup.

Senator ROCKEFELLER. We all do, don't we? My problem is that the VRA limit is my bill. I think what I'll do is ask Jonathan to continue the hearing. I have somebody calling when I have to go, which is not yet, but in theory it is going to be about 5 minutes. I think it will only take about 10 minutes to do the entire thing.

Mr. Hart, we welcome your testimony, sir. Please limit it to 5 minutes.

STATEMENT OF PATRICK HART, PRESIDENT, NATIONAL RURAL HEALTH ASSOCIATION

Mr. HART. Thank you.

Mr. Chairman and members of the Senate Veterans' Affairs Committee, I appreciate the opportunity to appear before this committee.

Senator ROCKEFELLER. If you'll put your entire statement in the record, that will allow you to condense it and keep your statement to 5 minutes. We accept it in the record, and it will be inserted immediately following your oral presentation.

Mr. HART. Thank you.

I would like to say, first of all, that prior to addressing some very key points having to do with solutions I want to mention that until mid-October it appeared that 1989 would be a banner year for rural health. However, on Friday, October 13, hope began to fade for the enactment of a 1989 rural health package. On that day the full Senate decided to strip down the 1989 reconciliation bill, thus eliminating an excellent rural health initiative and many other significant health provisions.

The package contained a number of provisions certainly familiar to the members of this committee involving an update for rural hospital, an expansion of the Rural Health Clinics Act, an the innovative approach to physician payment reform, a call for funding to States to establish offices of rural health, and an elimination of the urban/rural differential.

Due to the likelihood that the rural health initiative will not become law by the end of this congressional session, the National Rural Health Association strongly urges action by the House and the Senate to introduce and pass an omnibus rural health bill in 1990. Such a bill would contain the kind of provisions that I mentioned above, plus perhaps some others.

I do want to thank the members of the committee—especially the Chair in terms of his work on physician payment reform, and Senator Daschle in terms of the nurse practitioner bill, which includes direct reimbursement to rural practitioners. And I'd like to thank Senator Baucus for his work and note that he received an NRHA award for his work in rural health in 1988.

I think that the issues before us have to do, first, with being sure that rural health care in all rural areas to all populations is adjusted and fixed in such a way that special populations such as veterans have access, as well as other citizens. We have had severe problems of discriminatory medicare payments and declining inpatient utilization. We have had problems of viability of rural hospitals, and especially problems of shortages of personnel in rural areas.

My understanding is that in 1984 there was a report, and then again in 1986, and several steps were suggested. They included mail prescription program, hospital-based home care, and what was called medical district initiated program planning. I'd like to just say a word about what I understand medical district initiated program planning to be.

It involves allowing the local community to be responsive to the needs of veterans through the identification of those needs and combining the kinds of resources that are available. One thing that

I believe is happening in rural America today is that communities all across the Nation are mobilizing themselves to provide health care. To the extent that local communities and citizens can be involved in helping to determine health care, perhaps situations referred to earlier such as installing revolving doors instead of assuring direct patient care probably would not occur. So, it is very important that the VA continues to emphasize citizen participation.

I'm going to move on to the recommendations in my testimony and focus on certain issues. One is the National Health Service Corps. Obviously, physicians and nurse practitioners and physician assistants are in great need, as well as other health personnel. Many community health centers, community mental health centers, and other programs that can be a point of service for veterans in rural areas depend on the National Health Service Corps.

I am aware that Senator Daschle has introduced a National Health Service Corps bill this year, and the National Rural Health Association is in support of revitalizing the corps both for loan forgiveness and the scholarship.

We would hope that there would be flexibility in agency policy. The one thing that I'm very——

Senator ROCKEFELLER. You know, Mr. Hart, if I can interrupt—Senator Daschle, it strikes me as a very timely thing you did. The National Health Service Corps, as far as West Virginia is concerned, was one of few resources we had to get doctors. Frankly, 10 years ago we were getting 40 doctors a year. Now we're lucky to get four a year. It has just been obliterated in the last 10 years. So your reintroducing it and trying to get it up to where it used to be is very crucial.

Senator DASCHLE. Mr. Chairman, we've lost over 1,000 National Health Service Corps doctors on an annual basis. It is that bad. The budget for the NHSC has been zeroed out now. We're hoping to rebuild that because on Indian reservations and in VA hospitals and in a lot of needs that we have in Government today, without the National Health Service Corps you don't have doctors.

Senator ROCKEFELLER. And to continue interrupting, you and I have discussed before a fascinating statistic. If you look at low birth weight in this country, which has a direct correlation to whether a mother starts prenatal care in her first trimester, second trimester, third trimester, or not at all, there is almost a linear correlation between when she starts that prenatal care and the birth weight of that baby.

I was struck in my work on the Children's Commission by the State that had the highest birth weight—in other words, the State with the best birth weight in this entire country is North Dakota, and the State that had the worst record of birth weight—that is, the lowest birth weights, the worst kind of birth weights—is South Dakota.

I went to you and asked how that can be. How can North Dakota and South Dakota be at opposite ends? You said because you have eight Indian reservations, in South Dakota. You asserted that was the problem.

Senator DASCHLE. Well, that's correct. Two years ago we had 800 babies delivered on two of our reservations without the help of one OB/GYN. That's 800 children totally delivered by midwives, with

all the complications. One out of three Indian children are born—this is a little off the subject right now—with some complications in birth. But I thank you for drawing attention to that fact.

Senator ROCKEFELLER. But it needs to be.

Senator DASCHLE. It does tie in to rural health.

Senator ROCKEFELLER. What you're doing is crucial. In this country, every 2 minutes there is a baby being born to a teenage mother, and the probability of that teenage mother having decent prenatal care is not very optimistic.

My apologies, Mr. Hart.

Mr. HART. The National Health Service Corps is an absolutely essential program to care in rural areas. In addition, the 1986 report recited that there was a great need for flexibility in agency policy. I would believe that. I have seen that personally from my experience in being in upstate New York yesterday and being out in Burns, OR, about 2 weeks ago. There are differences in rural areas. There needs to be the kind of flexibility that allows for providing services to different population densities and different terrains.

We would also call for coordination between Federal agencies. Certainly the Veterans' Administration and Department of Health and Human Services working together could assure a more coordinated kind of health care in rural areas.

We also would look for support of H.R. 1742, reimbursement for reasonable costs for veterans receiving medical care at local hospitals. Representative Wes Watkins of Oklahoma recently introduced this legislation, and we would support that initiative.

I would like to say that veterans and all who reside in rural areas are encountering substantial difficulties. The kind of transitions that are occurring are ones that are affecting our very basic institutions; for example, hospitals looking at new ways of providing service. The medical assistance facility demonstration project that is occurring in Montana that is looking toward solutions.

We in the National Rural Health Association are interested in serving all rural Americans. We do have provision for looking at services to special populations, and we offer our services and our commitment to working with the veterans of America.

I am open to questions at this point.

[The prepared statement of the National Rural Health Association appears on p. 108.]

Senator ROCKEFELLER. Mr. Hart, I'll ask you one question and then turn to the other two Senators. This is a provocative question.

As you know, the VA health system has critics. Some of those critics have suggested that ultimately the most efficient thing that can be done for veterans is that the VA hospital system and health-care system be integrated into the American private health-care system generally. Your response?

Mr. HART. My response would almost have to be not to respond on behalf of the National Rural Health Association since we haven't addressed this as a policy issue.

But my response would go back to my work in southeastern Oklahoma where the Veterans' Administration medical center in the southeastern area was an important component of service. My sense is that there is room for some different flavors across the

country of the way we provide health care, but what is absolutely essential is that integration, whether it is ranging from very informal to fairly formal, is important. I think some degree of further integration may be of great value. I'm not sure that at this point a complete turnover into another form of ownership would be the solution.

Senator ROCKEFELLER. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Hart, what innovations in rural health care generally do you think are most applicable to rural veterans' health care; that is, to the more remote facilities like Miles City, MT, and Fort Harrison, for example?

Mr. HART. Well, I think that the innovations——

Senator BAUCUS. I'm thinking of telecommunications and all of these new, innovative ways that have helped in rural health. The National Health Service Corps, for example, is a part of it. But what comes to mind if you translate it and turn it over to veterans' hospitals?

Mr. HART. Telecommunication is an innovation that we talked about in our testimony as being applicable to veterans' hospital. I think that one of the most serious problems is trying to figure out how to find the right distribution of primary care and acute care facilities in areas that the Veterans' Administration hospitals may have to do outreach to.

So I would say that programs that involve use of nurse practitioners, programs that involve use of physician assistants, and ways to provide basic, primary care in rural areas that allow a continuum of care needed. For example I'm thinking of the comment about the person who doesn't know whether he or she as a veteran is eligible and they may have to be on a hold status waiting for basic care until they get to the center. It would seem to me that what we have to do is get primary care out so that people know to what extent they should be in contact directly with the larger facility.

Senator BAUCUS. That is exactly right, because we have medical assistance facilities referred to our State—and I know Senator Daschle has introduced national legislation on it. Those kinds of medical assistance facilities just seem to tailor to actual problems. It is a kind of service delivery that is not quite as expensive, but certainly a lot better than nothing. It helps a lot. I appreciate it.

Mr. HART. Sir, I'd like to point out also that I saw an example of the innovation of Montana health-care delivery system not too long ago. I was able to see how health care could be provided to about 1,900 riders in the Great Montana Centennial Cattle Drive as they went from Roundup to Billings. I think to be able to put health care on the road and move it with the cattle was an incredibly impressive experience to see.

Senator BAUCUS. Yes, it was. I rode in that cattle drive.

Mr. HART. For a week.

Senator BAUCUS. For a week. It was an incredible experience.

Senator ROCKEFELLER. We all noticed when you came back.

Senator BAUCUS. Well, you would have noticed more. Frankly, I was going to ride only 2 days. At the end of the second day I was having such a good time I just called up my office here and told

them, "Cancel everything. I don't care who is upset, I'm not coming back." At the end of the week I hadn't shaved or bathed in over a week. I had on dusty old boots and spurs that jangled when I walked and chaps and everything. My family is in ranching. I used to work livestock. It was good to get back into it again.

Anyway, at the end of the week I was very tempted, Mr. Chairman, to kind of give this place a little dose of reality and to come back as I was—just walk into the Democratic Conference as a dusty old dirty—hadn't bathed and shaved. Frankly, over the weekend I was getting a little reeking and couldn't stand myself any more, so I didn't do it.

But, anyway, there were several doctors in that drive, and the medical care was terrific. There were about 3,000 people just moving along. There were a few little incidents. People got bucked off of horses and there were a couple dislocated hips and so forth, but there was excellent medical care right there on the spot. It was very good. I appreciate that. Thank you.

Senator ROCKEFELLER. Mr. Hart, just one additional question for you. By next year, 1 out of every 4 veterans is going to be 65 years of age or older. By the year 2016, 46 percent of all veterans are going to be 65 years of age or older. As you look at it from a rural health perspective, this is a mammoth aging question, obviously common to our entire population, which we keep hearing statistics about. The fastest growth is coming among folks who are age 84 and older.

We keep hearing statistics. They go into our heads, but not into our policies. We're not preparing.

What do you think the Veterans' Administration is going to have to do in rural areas that it is not now doing to prepare for this extraordinarily rapid aging population of our veterans?

Mr. HART. Well, first of all the National Rural Health Association is very aware of the aging of America and the implications for rural health. We are establishing a task force to find ways to get all of those groups and agencies and organizations in the United States who address the health-care needs of the elderly to come together in a group and try to figure out how we can work in a coordinated fashion.

So one of the first things is for the Veterans' Administration to certainly work along with the others to look at services.

There is probably some increasing need for nurse practitioners, physician assistants, and primary care physicians to have a component of their training that deals with geriatric care. I think that just the sheer health manpower/health personnel issue to address the needs of the elderly is going to be a substantial problem. But I would say two things: we need to have coordination in rural areas. That includes coordination going from health promotion and disease prevention, which is often not thought of as particularly appropriate to elders, but which is extremely important in terms of maintaining their health and maintaining their ability to be at home and to stay in their community, all the way through the tertiary care.

We need a lot of coordination and perhaps some focused attention on how we can have health-care providers be much more aware and comfortable and capable of working with elder patients.

Senator ROCKEFELLER. I am constantly awed by the importance of rural health clinics to rural people. Rural people, many times, would prefer to not go to cities to get health care. Rural health clinics have a different philosophy and feeling. They are the folks who tend to go out to where people are. There is a major need in our country for rural health clinics. In Montana there are none. In Texas there are none. In West Virginia, thank heaven, there are 30. But the reason that there aren't rural health clinics in States where there are none is because they are not being promoted by Health and Human Services.

Now, do you have any judgment as to whether veterans use rural health clinics? Do they think only in terms of "I've got to go to a VA hospital?" Or do they understand that a rural health clinic is an incredibly valuable intermediary step?

Mr. HART. Well, sir, what I do understand is that I really don't have an answer to that. Earlier, on the way here, Ms. Sherry Kaiman, who is our legislative affairs liaison, and I were speaking about the extent to which we don't know exactly how many veterans are using rural health clinics, the extent to which veterans are in service areas of clinics. We were talking about the need and the action that we will be taking to try to find some of those answers. That's a tremendous resource.

As we looked through the materials that we had available we didn't have an answer to that question. To me that is an unanswered question and one of the several data needs in rural health care that we do need to find out. So I don't have that answer today.

Senator ROCKEFELLER. Could you try to get one for me?

Mr. HART. Yes, sir.

Senator ROCKEFELLER. Senators?

Senator DASCHLE. Mr. Chairman, I would just comment on a remark made earlier by Mr. Hart with regard to the concept of integration.

Integration is now being tested in two of our hospitals in western South Dakota, and it has really proved to be a very successful concept. I encourage Mr. Hart and his association—and certainly the VA, itself—to consider the success that has occurred with regard to integration; that is, taking resources with IHS and certainly opening our access on a space-available basis both in resources and space to people who use other Governmental facilities. To do that as successfully as we have in the western part of South Dakota gives me real hope that we can integrate the VA system in rural health-care needs much more successfully than we have thus far.

We have a facility there, albeit not totally adequately financed and resourced, but a facility, nonetheless, that serves a potentially tremendous population there that is not being served adequately today. So I hope that we can continue to see that and perhaps at some point in the future even lock into law the concept in a way that would make the most sense and use the resources to their greatest good.

Senator ROCKEFELLER. You know, Senator Daschle, rural health clinics can have a significant impact—West Virginia, I'm sorry to say, leads the country in teenage pregnancies. Lincoln County is a relatively poor, extremely rural county in West Virginia. You would assume that its teenage pregnancy rate, low birth weight

rate, and infant mortality rate are, therefore, higher than even our State's average. In fact, it is much lower. And it is primarily because of the rural health clinic in Hamlin, WV, which does extensive outreach and really addresses the needs of the community, including veterans in that county.

That means that the teenage mother, when she discovers that she is pregnant, feels that she has a friend in that rural health clinic. It is right next to the Giant Food Store. It is not a hospital. It is just a place. But it is a place people trust. It is just fascinating.

Senator Baucus, it makes it so important for Montana, which has none. The reason Montana doesn't have any is because HHS hasn't been promoting them and hasn't been pushing them. That's why Montana tells us they don't have them. They didn't know they could get them.

That's enough of that.

Mr. Hart, thank you very, very much. We are appreciative of your being here.

Mr. HART. Thank you.

Senator ROCKEFELLER. The next panel—and I have word now, Senator Daschle and Senator Baucus, that the VRA is now being considered and the Finance Committee is requiring a quorum. We're going to have to go there. Let me put this panel on and we should go there. I think we can markup the VRAs in 10 minutes and we'll come back.

This next panel—and I want to thank them, because each and every one of them has come a long way—consists of: Gary Burns, who is the Supervisory National Service Officer for the Disabled American Veterans from Maine; Jim Deremo, Service Officer, Department of South Dakota, The American Legion; Mr. Jim Nier, Commander of the Department of Texas, Veterans of Foreign Wars; Mr. Ray Seerup, Commander, Department of Montana, The American Legion; and Mr. John Woods, Texas Service Representative, Vietnam Veterans of America.

Gentlemen, we welcome you and we welcome your testimony. If you will give your testimony to Jonathan Steinberg, who will stay here in my place, we will be back instantaneously.

Oh, I'm sorry, Alan. I didn't even see you. Senator Simpson.

OPENING STATEMENT OF SENATOR SIMPSON

Senator SIMPSON. Here's my chance. We'll go forward.

This is a little unfamiliar. I used to have this power. Steinberg and I will run the world if they'll get out of here.

Let me ask, since my colleagues left me to do this—and it is very pleasant to be back doing this. But let me ask this fine gentleman from Wyoming, George Andries, if he could just take a seat here with this panel because I have to go over to the Senate floor. We're having quite a lot of activity today with Lech Walesa. We're to meet him very shortly and escort him to the House for a joint session of Congress. This is only the third time in our history where a nonelected official or a nonofficeholder is addressing a joint session of Congress. LaFayette was one. What do you think of them apples?

I'm very pleased that Senator Rockefeller called the hearing. I think it is very important to the country, and especially to those of us, such as Senator Daschle and Senator Baucus and Senate Rockefeller, who are very active with work on the issue of health care for rural veterans. I appreciate very much his calling the hearing.

I know that you have talked about great distances. I can match every bit of that in Wyoming where we have two VA facilities, Cheyenne and Sheridan, which are far apart. It is a huge State of 98,000 square miles and 465,000 citizens, and it's tough for them to get around. Beneficiary travel is important, but we saw a lot of abuses in that a few years ago. I hope those are being corrected. They should be.

We want to be sure we do not turn people away; and yet we want to be sure that when we do an entitlement program we have enough money to fund it. That has caused concern for all of you.

George Andries is the Director of the Cheyenne, WY, VA Medical and Regional Office Center. He is here today to testify about the needs of rural veterans.

If I might, I'd just ask him a question. Originally he was scheduled to be part of the third panel and I scheduled myself to do that, and then there was an adjustment. So with your patience, let me just ask a question as to what you see, if you could just summarize. We'll have your written remarks. Just summarize very swiftly, so we can go to these gentlemen, what you see as this issue as it confronts a small, rural, lightly-populated State.

We will accept all of that into the record.

STATEMENT OF GEORGE ANDRIES, DIRECTOR, VA MEDICAL CENTER, CHEYENNE, WY

Mr. ANDRIES. Senator, I thank you for inviting me. I, too, came from Chicago, and I have had my eyes opened, too, as someone earlier discussed.

I now come from your State, which you have described as the Land of High Altitude and Low Multitude, and the concept of distance is really earth-shattering. It is the biggest problem that we find.

I'm going to summarize this because the issue is one that is all pervasive. There is in Wyoming, as you know, no public transportation system of any note. If you are to fly from any city in Wyoming to any other city in Wyoming you must first leave the State. More importantly, if you are to use Air Evac, which is the Air Force system, we must drive our patients down to Denver, 125 miles away, to meet the airplane, even though there is an Air Force base down the street. We have a major problem with moving patients between our facilities.

We do the surgery for Sheridan, and we sometimes do it for Fort Lyons. Getting patients back and forth and getting psychiatric patients to places where they need to receive care is a real tremendous problem.

We also have a problem, I think, of just absolute need. This is great. Since I arrived in Cheyenne 3 years ago our work load, the number of individual veterans, has grown by 44.6 percent. That's up from 3,000 individual veterans to over 5,540 last year.

But last year, in the midst of our fiscal crisis, because of the financial problems we faced, we were forced to restrict our care to only those veterans who had mandatory entitlement to VA treatment. Consequently, we had to restrict eligibility only to those veterans who were category A eligible for inpatient care, and for outpatient care to those veterans who were receiving treatment for their service-connected injuries, were service connected over 30 percent, or were veterans service connected or nonservice connected whose annual income was less than $10,338.

As a result of this strict interpretation of law, the Cheyenne VA Medical Center dropped 651 individual veterans from its care, or 11 percent of its previous work load. All but 51 of those 651 veterans that were reluctantly dropped from the rolls were replaced by veterans who were category A or mandatorily eligible.

What we also find in examining our outpatient statistics is that 84 percent of our total annual outpatient visits come from the 10 counties in Wyoming, Eastern Nebraska, and Colorado which are within 100 miles of Cheyenne. The remaining 12 counties, including Natrona, which is home of Casper, our second-largest city, and is over 150 miles from Cheyenne and Sheridan, only accounted for 16 percent of our visits.

We know the need is there, knowing our statistics, and our issue is: how do you get out to those areas 100 miles or further away?

We believe that working together with other parts of the Government and with the State government we can meet these challenges in an efficient way. As you know, we are one of the nine combined regional office and medical centers. We saved a lot of money by combining our overhead. That's one of the things that we did very well.

But, for example, working together last year, and with the Department of Labor and the State of Wyoming, we established a Native American Tribal Service Officer in the Lander/Riverton area, which is 275 miles away. That person, who costs the VA not 1 cent to operate, brought $650,000 worth of benefits to Native American veterans who had never received them before and allowed us to bring over 219 of them down for medical care benefits. Again I say it didn't cost us anything. We worked together.

Under MEDDIP we have talked for several years about establishing an outreach clinic in Casper, WY. Working with the family practice residency, which is our only source of residents. We do not have a medical school in Wyoming, but we have two medical family practice residencies. They own a building up there. They have a clinic. Working together, we can establish a clinic up there which will provide over 11,000 visits, we estimate, and we can do it efficiently and at a much lower cost than if we were to have to establish something separately.

Our big issue is working together with all the parties to develop a whole, and that's where we are going.

[The prepared statement of Mr. Andries appears on p. 113.]

Senator SIMPSON. Well, I thank you very much. You do a splendid job as Director of that facility with new facilities coming onstream.

I have some questions, but I'm going to ask them in writing so that we can take care of these fine representatives of the veterans' organizations.

I think one thing I want to say is that I would certainly think that we've got to increase the coordination between Warren Air Base and the Cheyenne VA. That's absurd.

Mr. ANDRIES. Yes, sir.

Senator SIMPSON. It really is. In fact, I felt, when I chaired this committee and when I served as ranking member, that the DOD and the VA facilities should work together. It's a travesty that they do not. We ought to coordinate. We don't get it done. They love to run their own kingdoms. People don't even understand what the DOD facility is in America. They don't know CHAMPUS from chumps. We've got to make them understand what that is and what we do in this country and how important that is and how used it is, but how misused it is in DOD facilities. So we occasionally touch on honesty and dabble in that.

It is critical that we use those same facilities in Wyoming and not have to ship the veterans around even to Iowa for care, which was extraordinary to me when I saw that occur when this person could have received that same treatment at Warren Air Base or Denver.

I thank you for recognition of it, and I thank you for your work with it. You do a great job.

And now to our service organizations, Jim Deremo, Jim Nier, Ray Seerup, and John Woods, please proceed.

Since the Senator from South Dakota has come in, you ought to start, Jim. Here's your chance. How's that?

Senator DASCHLE. That is great.

Senator SIMPSON. I think that's the way we should do it.

STATEMENT OF JIM DEREMO, SERVICE OFFICER, DEPARTMENT OF SOUTH DAKOTA, THE AMERICAN LEGION

Mr. DEREMO. Thank you, Senator.

I do want to say it is a pleasure to be here. I know I don't have much time, so I will proceed.

There are a couple of things I'd like to touch on. First of all, when the VA says that they're not turning patients away, I think they are sidestepping the issue. For example, in the Sioux Falls VA Medical Primary Service Area, over the course of about the last year they have terminated care to roughly 3,000 patients because their condition has stabilized. These aren't just category Bs and Cs. Mainly these are category As—the service connected who are being treated for nonservice-connected disabilities and that sort of thing.

So when they tell you that they're not turning anybody away, for one thing that's not necessarily true, and, for the other thing, there are a lot of them that are having their care terminated, so they end up going out and they don't have the access to any other health care. Although the VA tells them they can come back, when that veteran gets that letter he thinks he can never come back to the VA. So I think there is a problem there, too.

We talked a little bit about the tractor. I'm glad that was brought up, because that is a real problem in South Dakota, for ex-

ample. As you know, the means test has a $40,000 net worth limitation on it. A veteran who happens to be a farmer and is nonservice connected may have $100,000 worth of land and has borrowed against it up to $100,000, but he may have a tractor or a plow or something that's worth $40,000. The average income in 1980 for a farmer was $8,000. Hopefully it has gone up a little bit since then.

So this farmer is sitting out there. He has $8,000 in income. He is in debt up to his eyeballs. And yet he has this tractor, so the VA is telling him that he can't come in and be treated. He doesn't have, as was pointed out—a lot of these people made decisions about their health care 20, 30, or 40 years ago, so they just didn't get health insurance. Now the cost is prohibitive and they can't get it. So they are really stuck. At least in South Dakota—and I suspect most of the rural areas—we don't have alternatives. If they can't go to the VA, there are not a whole lot of other places to go other than maybe go to the county and beg for them to pay their hospital bill. These are veterans that served honorably and expected their country to live up to that promise that was made to them.

There is another thing that I guess I see happening. Senator Daschle mentioned the $40,000 revolving door. It seems to me that if the resources of the VA were spent a little bit better—in addition to the $40,000 revolving door we also, about a year ago, got a $70,000 classroom. That was at about the same time that the VA was sending letters to category B's and C's and telling them that they couldn't come to the VA. It doesn't make a lot of sense to me. I work with these veterans every day, and it doesn't make any sense to the veteran. He gets a letter to the VA that says he can't come here any more, and yet we can build $70,000 classrooms. I think there is a problem there. It just seems like the resources could be spent a whole lot better.

As I said, there really are no alternatives. Our veterans in South Dakota do not have an alternative, really. A lot of them travel up to 200, 300, and 400 miles to the VA. We don't have county hospitals or another VA or anything, so a lot of these veterans that are being terminated and being told to go to their private physician and get the treatment there don't have the money to buy the private health care so, in a lot of cases, I've had them come in. For example, the veteran is a diabetic and takes his $200 or $300 social security check and buys his insulin so he can live, for God's sake. And then the Government ends up giving him food stamps and heat assistance and everything else, so you really haven't gained anything by terminating his care.

I guess if a diabetic goes home and can't afford the medicine and just goes home and doesn't take it and dies, then the problem is solved.

It is a big issue. Access I think is probably the biggest problem in South Dakota where, as I said, our veterans don't have alternatives. They either come to the VA or they don't. Most veterans—85 or 90 percent of them—don't even use the VA. But those that do feel very, very strongly that they should be able to go.

I would like to see this means test done away with. Do away with this $40,000 thing. Keep the third party reimbursement. Sioux Falls, for example, last year on third party reimbursement collect-

ed over $1 million. So there is an alternative source of money there that could be used.

[The prepared statement of Mr. Deremo appears on p. 119.]

Senator ROCKEFELLER. Jim, thank you very much. I read your statement, and the entire text of your statement will be inserted in the record. I think it is all the more appropriate just speaking from the heart and from your own experience. You shared so much with us. I know I speak for the whole committee in expressing our gratitude.

Let's move now to Mr. Jim Nier, the Commander of the Department of Texas VFW.

Mr. Nier?

STATEMENT OF JIM NIER, COMMANDER, DEPARTMENT OF TEXAS, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. NIER. Thank you, Senator.

First, let me say that I also appreciate the opportunity to appear before this committee.

We have been very fortunate in Texas, also, in that the secretary has visited us on numerous occasions since his position was elevated to the Cabinet level, and he understands the interests and the problems that we have in Texas, as well.

I come from a State that has 1 million veterans. We have some major problems in the rural areas. Specifically, I am from El Paso, which is in west Texas. We have a situation where we have a concentration of 58,000 veterans with no VA hospital. So when we say rural, it can also be a metropolis that has no hospital.

Our folks in El Paso travel 350 miles to Albuquerque, NM, or to the nearest VA hospital in Big Spring, TX.

We, like everyone else, believe that there is a need for a long-term commitment to continued medical care for our aging veterans populous. As everyone has alluded to this morning, that veterans populous certainly is aging.

One of the problems that comes along with that is the fact that many of these people are on a fixed income and their check is taken up in medical expenses, in many cases. My position in El Paso on a daily basis is Director of Veterans' Assistance for the county. I see many widows and veterans on pensions that come in and simply don't even have the money from their income to purchase the medicine that they need to maintain their health.

We feel that the veterans want and, of course, need this medical care, but they read articles and are told that they're wasting their time if they drive 200 or 300 miles to go to the veterans' facility because they may or may not be seen, they may be turned away. They get there and, in some cases, are, in fact, turned away because they haven't been given the proper information prior to departing for the facility.

We find in Texas that when they get there—the facility in New Mexico of the nearest facility in Texas—there's no place for them to stay, which is an added expense. We have some proposals, if you will, that maybe could alleviate some of those problems.

I don't know about my counterparts in the other service organizations, but we feel that perhaps some way of providing some tem-

porary lodging when they visit these facilities when they come in from these rural areas should be looked at or could be looked at in existing facilities, or maybe a ward or something that is not utilized in the facility that they are visiting. At least give the veteran some place to stay that evening or during the duration of his visit there.

We feel that more mobile health-care screening units are needed to go to the rural areas. I think that with the populous aging, as we said, maybe it is time that we go to the veteran instead of asking the veteran to come to the facility if there is extensive travel involved.

The VA could provide this health care to a larger number of veterans living in rural areas if they could provide these screening units with diagnostic capabilities, for example, and to tell the veteran if they need extensive care or tell them where to go.

We feel this could be done via vans, mobile units, or whatever. We feel that across the States these screening units could go into respective post homes—either Veterans of Foreign Wars post homes, American Legion post homes, DAV chapters, etc.—and let the veterans come there and be diagnosed with reference to their health problems.

We feel that public health nurses could be provided by the VA, again providing screening and basic health-care needs to a larger number at a reduced cost, realizing that the budget is a constraint.

It is a problem, as I said, in Texas. I can speak specifically for Texas. We have numerous, numerous people that are drawing a pension—both the widow's pension and the veteran's pension—and there is just not enough money to go around, not even to buy their medicine. A widow's pension today is $360 a month. A single veteran or a veteran with no dependents is $538 a month. When we ask them to travel plus buy their medicine it is a real constraint on them.

Senator DASCHLE. Mr. Nier, thank you very much for your comments.

Mr. NIER. Yes, sir.

Senator DASCHLE. We'll call at this time on Mr. Seerup.

STATEMENT OF RAYMOND L. SEERUP, COMMANDER, DEPARTMENT OF MONTANA, THE AMERICAN LEGION

Mr. SEERUP. Thank you, Mr. Chairman.

It is a distinct honor for me, as Department Commander of the American Legion of Montana, to appear before you and offer testimony on veterans' health care in rural areas.

The current crisis in rural health care impacts veterans in a number of States and is not a problem unique to the veterans living in the sparsely-populated Old West States such as Montana.

Montana has one of the highest ratios of veterans to total population in the United States. There is a population of 800,000, with 106,000 veterans, or 1 out of every 8 occupants in the State of Montana is a veteran.

The VA medical center in Miles City serves a veteran population of approximately 45,000 veterans spread over a 77,000 square mile area—an area larger than the States of North or South Dakota—

and also is one of the smallest of the 172 VA hospitals in the entire system.

VA studies indicate nationwide that 95 percent of all veterans live within 100 miles of the nearest VA medical facility. In the State of Montana, 83 percent of our veterans live outside of 100 miles of the nearest facility.

I might also add that in the last year 92 percent of the patients treated in Miles City earned under $16,000 a year, and over 60 percent of those veterans were below the poverty level.

With the exception of limited daily bus service, there is no public ground transportation to Miles City. In short, the problem has not been in treating the veteran at the Miles City VA Medical Center, but, rather, getting the veteran to the medical center for treatment.

With the arrival in late 1986 of a new hospital director in Miles City, James Huff, a new cooperative effort was enacted between veterans' service organizations and the medical center.

At the request of The American Legion, a meeting was held with Director James Huff and officers of The American Legion to institute programs that would equate into patient access to the VA hospital and dramatically increase the inpatient and outpatient activity.

A satellite clinic was opened in Yellowstone County, the largest veteran population county in the State. A veteran transportation network was established using buses and vans donated by The American Legion, the VFW, and the DAV. Three of the four vehicles donated are currently operated exclusively by veteran volunteers. In addition to that, the Miles City Hospital scheduled a fly-in clinic once a month bringing in specialists from the VA hospital in Salt Lake to treat veterans for special conditions.

A veterans outreach program was initiated in concert with The American Legion for Native Americans, female veterans, and Vietnam-era veterans, and The American Legion instituted "Veterans Awareness Programs". This is where veterans and all spouses were invited to attend and received information covering all major entitlement programs available to veterans and their dependents.

Our Congressman, Ron Marlenee and Senator Max Baucus—boy, you came in at the right time, Max.

Senator BAUCUS. We timed that well, right.

Mr. SEERUP [continuing]. Invited a number of congressional members to the Miles City VA Medical Center, and on August 25 of this year we were honored to have a visit by Secretary Edward J. Derwinski.

Each of these individuals left with a better understanding of the importance of rural medical care to veterans and, specifically, the role Miles City hospital plays with rural veterans.

These cooperative efforts between the VA medical center and veterans' service organizations resulted in a dramatic increase in both inpatient and outpatient activity to the hospital. But, due to the systemwide shortfalls in the fiscal year 1989 budget, the Miles City VA Hospital was forced to cut back and turn away nearly 800 veteran patients from outpatient services.

Since the inpatient census is largely dictated or created by outpatient activity, the inpatient census decreased proportionately.

Many of the veterans added to the rolls during the expansion period, including ex-POWs, were given 30 days' medication and told to seek medical care in the private sector.

Veterans turned away in rural areas generally find it more difficult to obtain alternate health care than in urban areas, due to the lack of certain physician specialists in rural locations.

Means test income limits and net worth disqualify many rural veterans from care who realistically had little spendable income—the $40,000 tractor. When men and women were called to serve their country, income or net worth did not exclude their military service; likewise, earned entitlements already bought and paid for through that active service should not be denied in VA health care because of income or net worth.

Among some of the topics to consider in improving health care in rural areas are bonus incentives for VA medical staff personnel in rural areas, established transportation networks soliciting volunteer support from veterans' service organizations, and establishment of a mechanism to properly fund rural VA health-care facilities.

We support the continued study of this matter through a VA task force, and we believe that such a study should have equal priority to other department programs.

Mr. Chairman, Senator Max Baucus, that completes my oral statement. Thank you very much.

[The prepared statement of Mr. Seerup appears on p. 129.]

Senator DASCHLE. As everyone can tell, the chairman of the Veterans' Affairs Committee has walked in. I call on Senator Cranston, the chairman, for any comments he might make and for conducting some other business that I understand needs to be done this morning here in the committee.

OPENING STATEMENT OF CHAIRMAN CRANSTON

Chairman CRANSTON. Thank you very much. I appreciate your courtesy in letting me come in the moment I walked in.

I thank you, also, for chairing this hearing. Unfortunately, because of scheduling conflicts, I cannot stay very long, but I want to welcome all the witnesses here this morning.

I thank Senator Rockefeller for his help in conducting this hearing.

I want to welcome all the witnesses—particularly Clarence Nixon, the director of the VA Medical Center in Martinez, CA, who will be testifying about VA's medical office in Redding, CA, a few hours to the north.

In order that the record of today's hearing contains more information about this innovative pilot program, I ask unanimous consent that a status report on the Redding facility, which I have asked VA to furnish, be inserted in the hearing record at an appropriate place.

I am pleased that the committee is again looking at issues of health care for veterans in rural areas. In July 1983, the committee held a hearing on this and other issues. Since this 1983 hearing there has been some positive action by VA, but also some cuts in

services to all veterans due to budget constraints. We need to learn how those cutbacks have affected care in rural areas.

In response to direction in VA's fiscal year 1987 Appropriations Act, VA set up two demonstration projects to test the most viable ways to improve veterans' access to health care in rural areas. One of these is the Redding, CA, medical office that I just mentioned. The other is in Farmington, NM. These facilities have been used intensively by veterans in the two areas and obviously fill a large, unmet need.

Also, in response to Public Law 98-528, the Veterans' Health Care Act of 1984, VA carried out a study of health care services to veterans residing in geographically remote areas. The report VA submitted to Congress in February of 1986 concluded that, "Generally, services are available and distributed evenly across regions of the United States", that "The major portion, 95 to 97 percent of the veteran population, has VA health services available within the distance of 100 miles," and that "inpatient and outpatient care services at VA facilities are being supplemented extensively by the use of alternative arrangements such as contract hospitalization, fee-basis outpatient care, and outreach programs."

VA's written testimony today provides a more complete history of the Department's involvement with rural health care issues.

We're here today to find out what is going on with rural health-care issues generally and within VA, specifically. We are here to find out if the positive and reassuring words from VA's 1986 report are still accurate. I expect that the committee will find that there is not adequate health-care for veterans living in rural areas; however, the past few years have been a time of severe budget problems in the VA health care system, and I don't foresee these problems disappearing, unfortunately, in the near future. We must evaluate the needs of veterans in rural areas in light of these budget realities. VA should be actively seeking cost-effective ways to improve services to all veterans entitled to care, including rural veterans.

I look forward to reading the transcript of today's hearing and may have a few followup written questions.

Again, I thank you all for being here.

I would call Mr. Nixon forward. I'd like to just ask a few questions of him out of turn on Redding, if we may do so.

Senator DASCHLE. Mr. Nixon, could you come to the table, please?

Chairman CRANSTON. Thank you very much, and good morning to you.

TESTIMONY OF CLARENCE NIXON, DIRECTOR, VA MEDICAL CENTER, MARTINEZ, CA

Mr. NIXON. Good morning.

Chairman CRANSTON. Would you please describe the catchment area, the geographic size, the population size, and the breakdown of service-connected and non-service-connected veterans for the Redding project, just very briefly?

Mr. NIXON. The catchment area covers a nine-county area of northern California—about 25,000 square miles. There are 68,000

veterans located within this nine-county area. The Redding community serves as a commercial and trading center for northern California and is 220 miles north of the Martinez facility, which serves that catchment area.

It is another 100 miles beyond Redding to the Oregon border, and then 100 miles roughly east or west to the corners of California through mountainous roads and bad weather in the wintertime.

The counties are, by and large, sparsely populated, except for Shasta County, where Redding is located.

The health-care facilities and the health infrastructure are rather poor. Very few of these counties have any really well-organized county health facilities or county hospitals. For example, the Shasta County Hospital closed about the same time we opened our medical office in Redding.

We activated the Redding medical office in April, a little over a year ago, as a result of this mandate for two pilot studies.

The office was designed to function as a group practice, primary care providers. It was organized around 4 primary practice physicians with about 12 or 14 people working in support of them.

We have a small building of about 4,500 square feet of space that houses basically three physicians. We didn't fill the fourth position because we were short on support staff and we had to divert that money to hire additional support staff.

The demand was projected at 15,000 visits. During the last year we had 19,000 visits. That raised the number of visits per 1,000 veterans from 214 to about 414 per 1,000 per year.

Now, to give you an accurate frame of reference, the VA average nationally is over 800. In the State of Florida, the similar figure approaches 1,200. We are now at 400 in Redding. To raise the number of visits per 1,000 veterans per year to be equivalent to the national average would require between 50,000 and 60,000 visits, and we're doing 19,000 visits.

Chairman CRANSTON. How well do you think the Redding project meets the needs of veterans in the catchment area? And what are the main obstacles in providing care to veterans who live significant distances away from the facility?

Mr. NIXON. Well, I think the problems that we have— I'm going to take your questions in reverse order.

The problems of distance I think have been very well described here by the various gentlemen from Montana and North Dakota. I don't think that our problems are any different. I think the numbers are different.

Senator Cranston, we have 68,000 veterans in that very isolated area up there in terms of its remoteness from VA facilities. There are 20 VA hospitals that have fewer veterans in their catchment area than this area of Redding which has a doctor's office. So the problem is that the 15,000 visits that were projected by the VA studies, as best I can understand, is based on some sort of a historical utilization rate. Well, if there is no facility there, then the utilization rate is going to be very low.

I think that if we had conducted this study and based it on some reasonable protocol that is based upon demographics, perhaps modified by income level or the age factor for veterans, that it would have revealed that a reasonable utilization rate would have

shown a need for a clinic that should be able to provide 40,000 to 55,000 visits.

This mandate did not provide any resources. It had to come out of the VA's resources. Our charge was to try to develop a model. We did. We took the 15,000 and we projected a model to serve about 20,000 to 25,000, which we would be able to do with that fourth physician.

Now, the second question had to do with the changes that I would make to problems that we're having.

We are providing radiology services from within the community under contract. We could provide that in-house with a savings of about $40,000 a year.

We provide pharmacy services, a 5-day supply, under contract at a cost of about $40,000 a year, but we still have to fill a prescription and mail it to the veteran, so we could bring pharmacy services in-house.

We are also providing laboratory services from within the community under contract. I think, in that case, that's the most cost-effective way to do it.

Problem: we have a doctor's office serving an area that needs a full-service clinic.

Chairman CRANSTON. Could I just ask you very briefly, please, one other question? What are the plans for a formal evaluation and report on the impact on the various obvious successes of the Redding pilot program?

Mr. NIXON. The HSR&D—Health Services Research Service — at Palo Alto is charged with evaluating these two pilot organizations for the agency and reporting back to Congress on that.

Now, I have to evaluate that, myself, as the responsible hospital director. Just coincidentally, about 6 weeks ago a task force that I put together to evaluate our experience with that clinic completed its report and submitted it to me. So, basically, the assessment that I'm giving you here is from that report, and it has the data and statistics to back up what I have said.

Chairman CRANSTON. Good. I just want to let you know that we are working hard to expedite the seismic corrections at Martinez also.

Mr. NIXON. I appreciate that.

Chairman CRANSTON. I hope that will come along swiftly.

I thank you very much for your responses to my questions.

[The statistical report of the VA on the Redding facility appears on p. 138.]

Chairman CRANSTON. Let me just say a couple of general things and then I'll be done.

Thank you, Jay, for handling this hearing.

Yesterday I received a letter from Senator Burdick about the proposed closure of a VA facility in North Dakota. He asked me to submit questions regarding the proposal in connection with the hearing, which I will do.

I'm sorry I can't stay for the rest of this hearing. I thank all of you for your participation and helpfulness.

I have one general announcement to make. The committee has received satisfactory responses in followup to matters covered at our November 9 confirmation hearing; hence, the committee will

convene in the reception area--staffers, please alert your Senators to this—of the Senate floor immediately after the first rollcall after 2 p.m. this afternoon to consider and vote on the nominations of Ted Lewis, David Lewis, and Ron Ray.

Jay, Tom, thank you very much.

Senator ROCKEFELLER. Mr. Chairman, we have more meetings in that particular room than any committee.

Chairman CRANSTON. We do our business very rapidly.

Senator ROCKEFELLER. And efficiently.

Mr. Burns and Mr. Woods, I apologize to both of you. I had not realized that you had not given your testimony. Please proceed.

STATEMENT OF GARY BURNS, SUPERVISORY NATIONAL SERVICE OFFICER, DEPARTMENT OF MAINE, DISABLED AMERICAN VETERANS

Mr. BURNS. Thank you, Mr. Chairman and members of the committee.

My name is Gary Burns. I'm from the State of Maine and I've been the National Service Officer of the DAV for nearly 20 years now.

I don't have a prepared statement. I'd just like to share with you some information and facts and figures.

First off, I will tell you what I will not do again. About 6 weeks ago I wrote the National Service Director, Al Wilson, and jokingly closed the letter by saying that this year I planned on keeping my office open during hunting season. Last week I got a call from Dave Gorman and here I am. But tomorrow morning I'll be about 30 miles west of Bangor, ME, deep in the woods instead of down here in Washington. I know what not to say to those people from now on.

A little bit of good news if I might, first off. I've been at Togas now for 18 years. I was born and raised in August, about 6 miles from there. I know the area pretty well. It is a beautiful facility, Senator. It has about 500 acres there. We have a swimming pool. We have a basketball court. We have a golf course, gymnasium, and weight room. DAV and the other organizations are in the process of purchasing the materials to build a boxing ring for the patients 'activities this Christmastime. We do this every year. This year we're going to actually put a ring together on a permanent basis.

All the organizations are involved in a number of activities. We put together a transportation program that has been a big help. We purchased a vehicle and turned it over to the VA.

A $24 million addition is presently being constructed at Togus. That's going to help out with recovery rooms, intensive care units, and improvements in support services long overdue.

What the veterans need most in Maine we don't have, and that is simply that we need more beds. We do not have them. We are authorized 570 beds at Togus, we have in use 299—and add to both of those numbers 60 nursing home care beds. That's for the entire State of Maine.

As of last January the budget shortages and reductions that took place resulted in the closing of a 30-bed medical/surgical ward at

the Togus VA, a 28-bed acute psychiatric ward, and 20 inpatient alcohol treatment beds. The outpatient chemical dependency unit we had in Portland for a short time has been closed. And we have already heard testimony from just about everyone who has spoken this morning concerning the elimination almost in totality of the category B and C veterans. As a result of all of this we have reduced the number of veterans support in the community nursing homes.

The gentleman down here spoke—I forget which State he was from, but it was familiar to me with respect to the needs that we have in the rural areas.

Two years ago the VA put together in Kerryville, ME, which is 280 miles north of the Togus VA facility, almost into Canada, an outpatient clinic that has been a big help.

We have kicked around the idea, and Senator Mitchell is very strong on the idea, and DAV even entertained possibly sometime back being involved in the financial support of the purchasing of a mobile clinical unit to travel down the eastern part of our State and up north. That will also bring some additional problems if we do that in that certainly the Kerryville clinic helps from the standpoint of veterans' outpatient needs. When it is diagnosed or recommended for inpatient care we have a problem with respect that we don't have the beds at Togus to take care of that.

We have 299 beds in the entire VA facilities in the State of Maine with 150,000 veterans. Of that, approximately 102 are psychiatric beds. About half of the remaining figure is intermediary beds. So intermediary—as far as I am concerned, we have 60 nursing home beds at Togus. That means there is another word for nursing home bed—it's a VA term, intermediary. Those people, for the most part, stay in that bed until they leave Togus to go to the Maine Veterans' Memorial Cemetery. That's what intermediary bed means at our facility at Togus.

In military terms, if I might, the analogy that I would use is: before we can spread out too much any more clinics or mobile clinics, we've got to make the Togus base camp a strong one before we start reaching out and rounding up more business, so to speak.

I realize the problems in all of the States that we have heard from today are very similar. I brought some facts and figures for you here that I could read to you, but with the background and history that you have heard about this morning, combined with your knowledge of what is going on around the rural communities, I don't think I need to do that. We share the same problems as South Dakota, North Dakota, West Virginia—I don't think I need to——

Senator ROCKEFELLER. I think Maine and West Virginia are the two most rural States.

Mr. BURNS. We're rural. I know that.

Senator ROCKEFELLER. Does that upset you, Senator?

Senator BAUCUS. Three most rural.

Mr. BURNS. I know that you can geographically put the rest of New England into the State of Maine. The gentleman on my left a few minutes ago said 800 miles. We don't have to travel that far, fortunately.

I would just like to say that I can share some of the problems that you, as the committee chairman, and all you people have here in Washington in that I am in the minor league, so to speak. I am involved with local politics in the capital city of Maine. You people are in the major leagues down here. We share some similar problems in that people call you asking for reduced taxes concerned about the budget. At the same time, they'll also call wanting their sidewalks and streets fixed. Sometimes it is difficult to know which way to go.

I know what the cost of living is. I know all about budget deficits. I have three teenagers, two in high school in Augusta—Coney High School—and one in Colby College in Waterville. He chose Colby because the distinguished Senator from Maine, Senator Mitchell, is from Waterville, and he chose to go to Baldwin, so my son went to Colby in Waterville. That was the distinction he made.

I'd just like to say—and I think some of these other gentlemen here have already echoed it, and I used this in a Veterans' Day speech a while back—that a lot of World War II veterans are suffering because of the budget shortages in the VA system.

The question was asked by one of the chairmen—you people have shifted around a lot today—of Mr. Hart about combining the private sector. I don't know about the other gentlemen up here at the table, but I can tell you that I want to make certain before that ever takes place that this Vietnam veteran is very lame, very disabled, and near death before you put me in bed next to somebody who took off for Canada 23 years ago. I wouldn't appreciate that, and I'm sure a lot of Vietnam veterans and other veterans wouldn't.

But there is one point that I want to make. There are a number of World War II veterans. If it were not for them, this country wouldn't have the opportunity to even be in a budget deficit.

Thank you, Mr. Chairman and committee members. I'll be glad to answer any questions you might have, sir.

Senator ROCKEFELLER. Thank you very much, Mr. Burns. I wish you well tomorrow, too.

Mr. BURNS. I'll be out in the woods very early in the morning, Senator, a longways from here.

Senator ROCKEFELLER. I'm getting that impression.

Mr. Woods?

STATEMENT OF JOHN WOODS, TEXAS SERVICE REPRESENTATIVE, VIETNAM VETERANS OF AMERICA

Mr. WOODS. I want to thank you for this opportunity to address the issues of rural veterans.

I want to begin by apologizing that the statement of the Vietnam Veterans of America was not on the table this morning due to a possible oversight beyond my control. I did not have anything to do with delivering this statement. However, I would like to suggest that all members of this committee please try to pick one up, because I feel it is a very assertive, powerful statement here which fully supports my colleagues at this table in addressing the issues.

Some of the primary issues in this statement are the beneficiary travel, medical school affiliation, contract services, services for mi-

norities and female veterans, special ambulatory programs, and relocation services.

I would again like to support all of the testimony that came up here this morning. I would like to commend the Senators for their assertive approach on bringing out some of the issues.

With the veterans that are going to the Veterans' Administration for medical services and being turned away at the door, I fully agree that that is a problem taking place in Texas. To add to that, I would like to suggest that my primary function is to prepare, present, and prosecute claims before the Department of Veterans Affairs on behalf of these disabled veterans.

When the veteran is rejected from the hospital for medical treatment on the grounds of not having an established, service-connected disability claim they come to me. I file that claim through the regional office, and the process may take as long as 4 months before the regional office normally issues a basic denial—it is somewhat of a form letter—denying whatever service-connected disability disorder we were filing for—on the grounds that the veteran's claim basically lacked in the way of supporting medical evidence.

The question being raised there is: how could he have gotten supportive medical evidence if he were not allowed to go to a medical evaluation for what he felt was service connected?

From that point we file an appeal. The appeal process is taking in the area of 8 to 10 months through the regional offices in Waco and Houston, TX, the two regional offices in north-central and eastern Texas.

What we're talking about here is a total time span in the area of 16 to 18 months before the regional office issues an order to the closest VA medical facility or outpatient clinic to do an actual medical evaluation for a determination as to it actually being a service-connected disability which would, therefore, make him eligible for benefits, treatments, medications, and so forth.

The course of this 16 to 18 months I find can very easily—and at times does very greatly—contribute to the deterioration of the disorder. Depending on the disorder, this deterioration sometimes is irreversible. I feel like this situation—very obviously, these circumstances those veterans that are not persistent in pursuing the claim—and I would like to add at this point one of the common phrases down in north-central and eastern Texas that the VA, by definition, is known as a veteran's "Vicious Adversary" in the course of this appeal process and finding adequate medical treatment and health services.

In the course of doing this, most veterans drop out of the process, become disgusted and go elsewhere, perhaps to vocational rehabilitation facilities within the State, the State Department of Vocational Training, and so forth, to seek medical treatments in county facilities, county hospitals.

One of the points that Senator Rockefeller brought up earlier that I would like to also address very briefly is that I would like to suggest vocational rehabilitation founded establishment by an act of law to fulfill the needs of disabled World War I veterans when there were not adequate VA facilities available to provide adequate service in all of the rural areas, and perhaps to expand on some sort of a Government subsidy program to the vocational rehabilita-

tion department, which is all over in each State across this country, to provide in-house services specifically for veterans in need of services where there are no facilities and no financial support system to get them to VA facilities. It might be a very appropriate direction to take, or at least to look into after this hearing.

Another point that I would like to bring up that has not been very deeply addressed in this hearing today is the matter of mental health care, which I find a very, very strong issue now in the Texas area.

Current legislation before the U.S. Congress clearly suggests that over 800,000 Vietnam era veterans suffer from a persistent emotional problem known as post traumatic stress dilemma. Of this, Congress is looking into the reality that only 10 percent of those that are being recognized through the RTI study are being adequately treated for this psychological disorder. Some of the common symptoms found in a PTSD affliction are—but are not limited to—depression, isolation, alienation, and basic feelings of rejection. Far too many times the individual with PTSD will come to the realization that he has failed to leave the shadow of his Vietnam war experience and come into the light of a normal, productive lifestyle within mainstream society.

He will seek adequate consultation for this affliction through the Veterans' Administration. He faces many of the functional realities that we have discussed here today it may become emotionally damaging for the veteran to face these problems—do I need to stop now. This is my first hearing. Do I need to close or can I continue?

Senator ROCKEFELLER. Just about another 30 seconds is all we really can—

Mr. WOODS. OK. Well, then, in conclusion, thank you for this 30 seconds.

Based on the differences found between the VA's theory of design for delivering adequate health-care services and the reality of functional performance as it creates very negative results for rural community veterans and certain minority veterans, I feel it essential to identify the enormous needs for veterans to be accepted into the decisionmaking coalition where the process is found relative to the delivery of VA health care.

Who would know more than those veterans who have actually faced these differences between design theory and functional reality of delivery how to recommend productive alternatives?

When the veterans' health care is the question, the veterans' contribution and answer can only be found productive.

I appreciate this opportunity and would gladly entertain questions.

[The prepared statement of the Vietnam Veterans of America appears on p. 178.]

Senator ROCKEFELLER. Gentlemen, the joint session of Congress will begin soon, Senator Baucus would like to ask a question now. I'm going to submit questions that other members have for you in writing and would ask that you reply to the committee by the 1st of December. I think that should be possible.

Senator ROCKEFELLER. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Ray, you are Department Commander for the American Legion from Montana. You travel around the country a lot and around Montana a lot—particularly with the van that you have provided from the Billings area to Miles City and back.

Could you give this committee a flavor of the comparison between health-care service to most veterans in the country—particularly those who live in and around cities—compared with veterans' health care delivered to veterans in very remote places, or at least a long way from a hospital or a medical facility? Can you just give a flavor? You have talked to a lot of people around the country and have seen a lot of facilities around the country. I'm just curious if you could, in your own words, just describe what the differences are so that this committee has a little bit better idea.

Mr. SEERUP. I think I understand your question, Max. Number one, the Miles City operation a very few years ago—like 3 or 4 years ago—had a reputation of a place to go to die. A veteran only went there if he was on his death bed.

Administrative leadership in the hospital is very, very important. Of course, I emphasize that with the addition of Jim Huff, who took over as director of that hospital, the first thing he did was get a medical chief of staff by the name of Dr. Donald Holt who set aside principles and policies for the medical staff and support staff, right down to the janitors, on how that hospital would be run, what was expected of them, and what contribution they were expected to make to the overall success of the hospital.

Very dramatically, within 30 days things changed at Miles City—right now, the veterans who go to Miles City would prefer to go to Miles City for treatment over two very major hospitals that we have in Billings—Deaconness and Saint Vincent's Hospitals. One is number two in cardiovascular operation success in the United States.

I think all of this comes with what we've got to do with veterans. We have to again instill a sense of confidence in our own VA medical system, which has been torn apart for a number of years. The insecurities of whether a veteran goes on a Monday to a VA hospital and then will have the capability of returning for additional treatment on Friday are questionable.

So many of the veterans that were turned away—I know for the 800 or so that were turned away from Miles City, The American Legion in Montana, in cooperation with the VFW and the DAV, is out to sell the hospital back to those 800 people. I'm sure that a number of those are not going to return. They're going to say, "Hey, I've gone through this stuff before and I'm not going to go back and have it done again."

Another thing—and this is off of your question a little bit, Max, but I want to address it, and I'm sure that my constituents here at the table have run into the same thing. With Public Law 99-272 that created this God-forbidden A-B-C system that we live with now, and then the addition of Public Law 100-322 which further prioritized category A, we have now set up discretionary medicine on all B's and C's and a large part of our category As because of those two laws.

Veterans that have been treated in VA medical centers for years, ever since the end of World War II—some of them for 35 or 40

years—have been turned away from medical treatment because they are no longer eligible because they fall within the upper limits of that income level on category A or what have you. These individuals don't have insurance. They are uninsurable. They have limited, fixed incomes of perhaps $15,000 to $18,000, which makes them category B. But we literally took those veterans and gave them a kick in the pants and told them to get out and don't come here. Go to the private sector. These guys don't even know where to go. Some of them are in their 70s. They are lost. They are like lost sheep out there trying to figure out what they're going to do with their civilian life.

So they just say, "Well, the hell with it. I'll just go home and die and let it go at that. They don't care about me anymore."

So I don't know how many of my constituents have run into the same problem, but that is crucifixion of a veteran when we treated him for 40 years and then pull the rug out from under them.

Senator BAUCUS. That's exactly right. In fact, as you were speaking I saw lots of heads nodding. It is obvious that those others testifying with you have had the same experience in their particular areas.

You provide a great service, Ray, to the State of Montana and to the veterans of the State of Montana in various ways. One is to help with the transportation service which is so vitally needed. The second is, as you have mentioned, to make more Montana veterans aware that the nature of the quality of the service at Miles City is first rate. The more veterans know that, the more we're going to have better veterans' health care in the State.

We're pressed for time here, so I can't go into much more, except to say I'm glad you are here to help educate the committee as to the importance of rural health care. Senator Rockefeller knows that, but there are others that need to know that, too.

Mr. SEERUP. Senator, as a matter of record, Montana proves that Republicans and Democrats make good bedfellows. We have a Congressman, Ron Marlenee, in Montana who has been a very big stalwart for the veterans of Montana, as has Senator Baucus. One is the donkey, and the other the elephant. But we found that the progress in veterans' entitlements is really made. It is a nonpartisan issue in Montana, and both of these gentlemen have proven it time and time again. Without these two guys I think we'd have a past hospital in Miles City that would have been closed.

Senator BAUCUS. You're exactly right.

Mr. SEERUP. We appreciate that.

Senator BAUCUS. Congressman Marlenee has made a major contribution in bringing various people to eastern Montana—and particularly to Miles City. You're right. Congressman Marlenee has done a terrific job. Thank you.

Mr. SEERUP. And so have you.

Senator BAUCUS. Thank you.

Senator ROCKEFELLER. Thank you, Senator Baucus.

Gentlemen, as I indicated before, I may be sending questions to you. Thank you very much.

The final panel consists of: Mr. Robert Daisey, the Clinical Coordinator of the Bangor Veterans Center, Bangor, ME; Dr. Francis Goldstein, Associate Chief of Staff for Ambulatory Care, Columbia,

SC; Mr. Clarence Nixon, Director of the Martinez, CA, VAMC and Director of the VA Redding Medical Office in California; I'm pleased to say, Mr. James Powell, Director of Social Work, Beckley, WV, VAMC; and also Mr. George Andries, Director of the VA Medical Center, Cheyenne, WY, even though he has been here before.

Because of the situation with the joint session, what I'm going to do is to ask a series of questions to Jim Powell, and those questions will also be asked of the rest of you gentlemen, but they will be asked after I have to leave by Jonathan Steinberg. And then there will be other questions that he may wish, on behalf of other committee members or himself, to ask each of you gentlemen.

Mr. Powell, would you take a minute to describe for the committee your facility's catchment area; that is, who comes to you? We'd be interested in geographic size, population definition, and then the breakdown of service-connected veterans who come and nonservice-connected veterans.

TESTIMONY OF JAMES M. POWELL, CHIEF, SOCIAL WORK SERVICE, VA MEDICAL CENTER, BECKLEY, WV

Mr. POWELL. We service 11 counties in West Virginia and 1 county in Virginia. It is a very mountainous region. We service a population of 47,000 veterans in that area, and 93 percent of the veterans we see at the VA medical center in Beckley are either service-connected or category A veterans, which are mandatory treatment.

[The prepared statement of Mr. Powell appears on p. 191.]

Senator ROCKEFELLER. You've stated that the Beckley VA provided 197 days of respite care last year. Can you describe the typical veteran and his or her family who receives respite care services and reflect on the importance of those respite care services to that family?

Mr. POWELL. All the veterans that we served were either service connected or nonservice connected with aid and attendance or housebound benefits. They basically suffered from organic brain syndrome, Alzheimer's disease, or other debilitating diseases which made them unable to function without a primary care giver.

Respite is very important to the care givers because it supports them, keeping the veteran at home. Without the respite care program in Beckley, these individuals probably could not remain in the community.

Senator ROCKEFELLER. In your experience, has the Beckley VA seen an increase in the number of veterans without any health insurance? That's a matter of very great importance to me.

Mr. POWELL. I don't have that information. We do, again, see—the majority of our patients are service connected or nonservice connected on a limited income. They're all mandatory—93 percent of them are mandatory treatment. I don't know about the insurance.

Senator ROCKEFELLER. If it would be possible, I would really like to have that information if there is a way of getting at it, because this whole question of people that do not have health insurance and whether or not they can get health care, whether it is avail-

able to them, is very, very important to me. If you could get that to me I'd appreciate it.

Mr. POWELL. Yes, sir.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Yes, we have seen an increase of non-service-connected veterans without insurance coverage. Fifty percent of our veterans registered in our computer files have no private health insurance. During fiscal year 1988 we were able to bill private insurance compaines in 353 NSC cases. In fiscal year 1989 we filed for insurance reimbursement for 334 NSC veterans. This represented a 7 percent decrease in the number of insured non-service-connected veterans over the previous fiscal year.

Senator ROCKEFELLER. Also, in your judgment, Mr. Powell, how does your facility meet the needs of veterans in your catchment area? What are the obstacles that your facility faces in providing services to those veterans who live significant distances from your facility? What kind of obstacles are there, as you see them?

Mr. POWELL. Certainly the main obstacle is public transportation. No county in our catchment area has public transportation. Some have commercial transportation, but it is limited to the interstate routes.

We have tried to address this issue by doing a cooperative venture with the DAV of West Virginia where they provide drivers and a coordinator, along with our social work service department. We screen veterans and refer them into this program. It is called the DAV transportation network. This provides about 35 veterans a month with transportation. Without this network, they wouldn't be able to get services.

Senator ROCKEFELLER. How long has that transportation service been in existence?

Mr. POWELL. It has been in existence for about a year and a half now.

Senator ROCKEFELLER. Can you describe for me, Mr. Powell, the sense of ease or lack of ease with which a veteran confronts a VA hospital in your area? In other words, people sometimes are reluctant to go for health care and, in fact, sometimes people don't want to because they are afraid that when they consult a doctor they'll be given bad news. Sometimes it is better not to know about bad news, so people don't health care. Do you see that as something which holds back veterans, particularly in rural areas?

Mr. POWELL. I think that in any rural area where health care isn't understood there might be a reluctance to seek out medical treatment. There is always the odd case where a veteran or any individual has cancer or some type of chronic illness or terminal illness and he refuses to seek help because he doesn't understand that help is available. I think this is a problem of educating and getting the word out what medical science can do to help people and make it available to everyone.

Senator ROCKEFELLER. That's a classic definition. In other words, a rural person may not know what is wrong with him or her and may not know whether to do anything about it. This is really a question of outreach.

How is that done? How would you like to see it done in West Virginia?

Mr. POWELL. Outreach in the rural area is very difficult. We use our veterans' service officers and our veterans' service office meetings to let them know what is available and they help us disseminate the information about our medical center. We have a very, very strong veterans' service organization population, and they are very good at helping us get information to the general populous.

Senator ROCKEFELLER. And you're well satisfied by that, then?

Mr. POWELL. Well, you can't be 100 percent satisfied, but we do what we can with the resources we have.

Senator ROCKEFELLER. I want to ask Mr. Daisey, on behalf of Senator Mitchell, who had planned to be here this morning but wasn't able to make it. He wanted specifically for this question to be asked to you, Mr. Daisey.

Mr. Daisey, in your experience, are existing mental health centers and therapists and private practice in rural areas interested in providing readjustment counseling under contract with the VA? If not, why not? What could we do to make this a more attractive option for them?

TESTIMONY OF ROBERT DAISEY, CLINICAL COORDINATOR, BANGOR VET CENTER, BANGOR, ME

Mr. DAISEY. As what you were talking about before, the outreach part of it is really needed. No, I don't think there is an interest there right now because right now our contract fee program is looked at by mental health providers very much like they would an insurance program, a third-party payer; yet, the skills needed to give readjustment counseling to the veterans are not there. There needs to be training, education, consultation, and outreach not just with the clients, not just with the clergy in the areas and service officers, but the professionals to teach them, to train them in how to give these services.

I think we need to look, whether it be through grant moneys or something, at developing some startup money for programs to develop a program for this outreach effort and for this training effort.

Then, I think when you have trained providers, they have some motivation besides just third-party payer dollars but some motivation to give those services and the skills required, then I think it is possible to be done.

Senator ROCKEFELLER. I appreciate that, Mr. Daisey.

I now have to go. I apologize for that, but this joint session is important. Jonathan will continue with the line of questioning that I have started.

I want to say before I go—and this is important to me because it is the kind of thing that usually doesn't happen very often. Dr. Winship and Ms. Quandt and other VA officials did not get up and walk out as soon as they finished their testimony, which is so often the case. They have stayed during this hearing and they have listened to what people have had to say and, frankly, that's important to me. I want that to be a part of the record.

Mr. Powell, obviously I am very grateful that you are here from West Virginia. I appreciate all of you being here very much.

I apologize for my departure. Jonathan Steinberg will continue the line of questioning.

Thank you, gentlemen, very much.

Mr. STEINBERG. Mr. Nixon, the next two questions Senator Cranston has already asked of you, so I will ask you to pass as we go down the panel and we will start with Mr. Daisey and work down for the first question.

Would each of you take a few minutes to describe your facility's catchment area, its geographic size, the population size, and the breakdown of service-connected and non-service-connected veterans?

Mr. DAISEY. We're a small outreach center, a four-man team. Our catchment area comprises of the eight most northern counties in the State of Maine. We're talking about an area of 24,165 square miles. So we have a huge area to provide readjustment counseling. Of course, the unique part for us, I think, is that many of the veterans that we serve have moved into this area, and the things that make them hard to reach are the reasons they moved there. Many Vietnam veterans who are dealing with readjustment issues are seeking isolation, and so they move into the most northern parts of the county. I think the major focus in our area is the most northern county, which is Aroostook County, which is over 6,000 square miles. This is the most northern county in the State of Maine, and it has got about 21 percent of the veterans that we are mandated to serve. Many of these veterans have moved into this area from urban areas in order to seek this isolation.

Mr. STEINBERG. Do you have a sense of the service-connected and non-service connected breakdown?

Mr. DAISEY. For us, it is our mandate to provide readjustment counseling, it is not on a service-connected basis.

Mr. STEINBERG. I understand that. Do you have any sense of the break down that at all?

Mr. DAISEY. I would have a sense that about 35 to 40 percent of the veterans that we serve in Aroostook County are service-connected, many of them to a high degree. I'd say a majority of those that are service connected are over 50 percent service connected for post-traumatic stress disorder.

Mr. STEINBERG. Thank you.

Mr. Nixon, unless you have something to add to your prior answer we'll skip you and go to Mr. Andries.

Mr. ANDRIES. The Cheyenne VA Medical Center and Regional Office Center actually has two Primary Service Areas (PSAs). From the medical center standpoint we are responsible for 11 counties in the central and southeastern part of Wyoming, and 8 counties in eastern Nebraska. That goes from Ogallala to the Wyoming border.

Mr. STEINBERG. How many square miles are we talking about?

Mr. ANDRIES. I would say that if we're talking 98,000 miles, we're talking half of that distance—roughly half of that distance on the total State. As the regional office for Wyoming, I am responsible for the entire 98,000 miles. To give you some idea of that distance, to go from Cheyenne, which is in the extreme southeastern corner, to Jackson, where the recent minisummit was, is equivalent from going from Washington, DC, to Manchester, NH. And you will not see as many people on that trip as you will here in Washington. It is a long distance.

In our PSA, the Indian Reservation which we take care of, the Wind River Reservation, is 275 miles away. This is a drive where you will go stretches of 150 miles and not see anything.

The other thing we do take care of, which is very interesting—we are in the far southeastern part of Wyoming. We actually get a large proportion of our veterans from the three northern counties in Colorado that drive up to us. They choose to come, even though they aren't technically in our primary service area. We like to laugh and say that the yuppies go south and the cowboys come north. It really is a self-selection type of operation.

As I was saying in my testimony, the second-largest city in Wyoming, Casper, which is part of our catchment area, is over 175 miles to the border of the county.

Mr. STEINBERG. Do you have a sense of the service-connected/nonservice-connected situation?

Mr. ANDRIES. I would say the service-connected/non-service connected—right now in the hospital we are seeing 98.2 percent of our outpatient visits are within category A. I don't have that data, but I can provide the exact data.

Mr. STEINBERG. If you could provide that, we would appreciate it.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

We do not have exact data on the number of service-connected and nonservice-connected for all veterans living in our catchment area. However, the following information is provided concerning the service-connected status of the individual veterans we provided service to in fiscal year 1989:

Total fiscal year 1989 unique veterans	5,530	
Service-connected veterans	1,984	(36 percent)
Nonservice-connected veterans	3,546	(64 percent)
Total fiscal year 1989 unique veterans in our PSA	4,217	
Service-connected veterans	1,453	(34 percent)
Nonservice-connected veterans	2,764	(66 percent)

Mr. STEINBERG. Doctor Goldstein? If we get to the end of the panel and you want me to repeat the question, please don't hesitate to ask.

TESTIMONY OF DR. FRANCIS P. GOLDSTEIN, ASSOCIATE CHIEF OF STAFF FOR AMBULATORY CARE, VA MEDICAL CENTER, COLUMBIA, SC

Dr. GOLDSTEIN. I never thought of South Carolina as being particularly urban, but after hearing the stories about Wyoming and Texas and even California I feel relatively cosmopolitan here. In fact, we are 27th in the country, right in the middle, as far as the Census Bureau is concerned, in the ratio of urban to rural population, and about 50 percent of our population lives in urban centers and 50 percent lives in rural areas.

We have 352,000 veterans, and about half of them are rural. The State is not terribly large. I think it is 30,000 square miles.

Do you want service connected and nonservice connected?

Mr. STEINBERG. Yes, if you can give us some sense.

Dr. GOLDSTEIN. It is 51–49, and I forget which one tips the balance at any given time.

Mr. STEINBERG. Is that both inpatient and outpatient, or just outpatient?

Dr. GOLDSTEIN. That's the catchment population, as a whole.

Mr. STEINBERG. I see.

Dr. GOLDSTEIN. And I think that reflects more the outpatient work load than anything. We have 94.6 percent in category A.

[The prepared statement of Dr. Goldstein appears on p. 195.]

Mr. STEINBERG. Mr. Powell?

Mr. POWELL. Again, our catchment area is a rural area, very mountainous. There are 47,000 veterans in our catchment area. There are very limited services for any individual, and they have to travel a great distance over very, very narrow roads, in most cases.

Ninety-three percent of the veterans we see are category A veterans. They are mandatory treatment. I guess we have 6 percent that are category B and C.

Mr. STEINBERG. Thank you.

We'll start this question with Doctor Goldstein and move back. I think Mr. Powell already answered it. Senator Rockefeller asked this question before. How well do you feel your facility meets the needs of veterans who are within your catchment area? And what obstacles are there at your facility to providing care to veterans who live significant distances away?

Dr. GOLDSTEIN. I'll answer the second part first. It's easier.

Mr. STEINBERG. That seems to be the character of that question.

Dr. GOLDSTEIN. The barriers are three, I think: distance, poverty, and ignorance. I guess those are the three answers to almost any question. Distances are great. They are probably not as great as they are in the West, but fully 40 percent of the veterans in our State—this was shown in one study that was done recently commissioned by a representative—do live 60 miles or greater from a VA facility, whether that would be a hospital or a clinic, we also make use of that. We have an outpatient clinic in our State.

The situation is, of course, compounded by poverty. Our State is not very rich. I think in 1986, when the median income in the United States was $14,000, in South Carolina it was $11,000. And we have lots of little communities out in the countryside where the per capita income is under $5,000 a year. Those folks don't have a lot of resources to get around with. They also don't have a lot of sources to avail themselves of alternate sources of care, even if those were available.

Unemployment is a problem, of course, in the rural areas everywhere, I presume. With unemployment comes lack of health insurance and other sources of care.

The third barrier which I think hasn't been spoken to but which amazed me was that in 1987 the VA commissioned a survey of veterans from the Census Bureau, and it is published as a book. You can buy it or read it. It is called "The 1987 Survey of Veterans."

They went out in the countryside and actually asked veterans who did not come to the VA why they don't come. Great hospitals are out there. Why don't you use them? There were a whole string of reasons. Number one is that they weren't sick, and things like that. But, surprisingly, only 8.5 percent of the respondents said that it was because the medical center was too far or they couldn't

get there or they had no transportation. That's still a significant percentage, and it was higher in some subgroups. I think it was 13 percent in elderly veterans or in poor veterans.

But the number one reason seemed to be ignorance. Of the veterans that they polled, 48 percent didn't know that the VA would accept them and that the VA even offered hospital care to nonservice-connected veterans with low incomes; 41 percent didn't know that we offered outpatient care; 34 percent didn't know that we had a dental service. So that's a huge problem, and I think it's worse out in the countryside. The further you get away from the big city media and the sources of information, the worse that tends to be.

Mr. STEINBERG. How about the other part of the question? How well do you feel your facility is doing in meeting the needs of rural veterans?

Dr. GOLDSTEIN. I think we're doing better than some of the others because our obstacles are not so great. In fact, if you look at that 400 visits per 1,000 veterans that was cited in California, for us, if you look at the veterans in our rural regions where the VA facilities are located, we're at 1,120 visits per 1,000 veterans. And even if you go way out in the countryside, the furthest county from a VA medical center, we're still averaging 930 visits per 1,000 veterans per year, and that's due to a combination of factors—some beneficiary travel, solutions I think we'll talk about later, maybe.

Mr. STEINBERG. Mr. Andries?

Mr. ANDRIES. I think, as I said before, we have several problems. One is the greatest—geography. You ask how we are treating veterans? The ones in the 10 counties that are closest to us, within 100 miles—and that's a daily commute in Wyoming—we're doing a very good job. The increase in the veterans is testimony to that. The issue is whether we can recruit physicians continually to get in there to provide that.

If you ask me how we are doing in providing distance over 100 miles, we're doing very poorly because we can't get to them or they can't get to us easily.

Now, no veteran has ever been turned down because he couldn't get here, because every director has the ability to get a veteran there. I want to make that abundantly clear. We all can do it if we have to. And we do it.

But to routinely come to outpatient visits which are 150 miles away—which is, in essence, what we are trying to do—you can't do that. It is too long. We need to look in moving to resolve this problem.

For us, the answer to both is approximately the same thing. In Wyoming we have no medical schools. Mr. Rockefeller talked about that. But the State in their wisdom—and I think it was wisdom—developed family practice program residencies to train and bring in family practice residents. We are working increasingly more with those family practice residents to put those type of practitioners out in the areas and then use our place as a referral area back to us so that the day-to-day followup can be happening.

Mr. STEINBERG. Where are those family practitioners located?

Mr. ANDRIES. There is one family practice in Cheyenne, which we work with, and the other one is in Casper. They have another program there.

As we look to expand, we look to expand the clinic in conjunction with them, because not only will it help us to cut the cost——

Mr. STEINBERG. Excuse me. Are they contracting with you?

Mr. ANDRIES. No. We have not gone to Casper yet. Right now we get a lot of it for free and we are working out arrangements to try to share the cost with the State of Wyoming as best we can because they are having budget crises, too. Wyoming has just been decimated by the drop in the oil industry.

The other area that we do have a major, major problem in Wyoming is in mental health areas, and I wanted to address this because I happen to agree with another member of the panel.

To provide psychiatric care, which is a tremendous need in the State of Wyoming—we established a new clinic. As I said, there are only 19 non-VA psychiatrists in the whole State. That's one per 25,000 people. You can't provide psychiatric care and have the person drive 200 miles every day. You need to have it somewhat close to him.

Yet, PTSD, in our experience, is exactly the same. It is something new that they don't know how to treat. What we really need to do is utilize some of the existing facilities but to train the people on how to provide the treatment and also to establish a plan that we can follow up on, because what we find, if you put somebody out on contract for psychiatric treatment, is that amazingly enough they never get better.

What you need to do is to supervise this type of illness. We are looking with the PTSD issue to train people at the local mental health centers to treat PTSD, again to work with the State of Wyoming, who is as broke as the government here is, and together we try to form an alliance to try to provide these services.

As I said, the final answer to the question is: are we providing a good service? Yes, we are locally. Can we do better? Yes. If we are going to do better we need to have some outreach clinics into those areas so the people can get access to the area.

Mr. STEINBERG. Clarence, I notice you've brought the microphone over. You may want to embellish what you said to Senator Cranston earlier on this particular issue.

Mr. NIXON. I addressed his questions with regard to the Redding Clinic. I think our questions now are being answered in the context of our entire catchment area.

Mr. STEINBERG. Fine.

Mr. NIXON. Are we doing a good job, certainly——

Mr. STEINBERG. Why don't you briefly describe, for your brethren on the panel, the geographical size and population size of the Martinez location.

Mr. NIXON. We are the closest thing to a hospital in northern California. As I indicated earlier, we're located halfway between the Oregon border and the Mexican border. We serve northern California from the East Bay of San Francisco north to the Oregon border, excluding the counties that touch the water.

There are 425,000 to 450,000 veterans in our catchment area. The Livermore Hospital to the south of us has 125,000 veterans in its

catchment area, but it is a long-term care facility. So we, in Palo Alto, can debate who takes the lion's share of that. So we have over 500,000 veterans that we are serving, and that is more than twice the number of veterans in the average catchment area of the typical 400-bed, full-service affiliated hospital with an average budget of around $75 million. Our budget is a little more than that because we're heavy in the outpatient.

Now, within that frame of reference, what are your indices? Are we doing a good job? Yes, we are, given the dollars and the resources that we have. We are a very highly productive hospital. Yes, we are in terms of the quality of the care that is provided to the veterans we serve. We are doing a fair job of resolving the access problems because we probably, as much as any VA facility, by design and strategy have directed our dollars into ambulatory care.

We have, in the past 13 years, built and activated a clinic in Sacramento. Just a year ago we activated a new clinic in Oakland. We put a substance abuse clinic in Berkeley. We have a day hospital in another facility in the East Bay area. We have the Redding Medical Office facility. So we have about the 10th or 12th largest outpatient program in the VA system, although we're probably 60th or 70th if you were ranking us in terms of our operating budget.

Mr. STEINBERG. The major reason for this is not only the size of the population you're serving but because of all of these outreach efforts that you've undertaken.

Mr. NIXON. Well, 97 percent of the people's lives we touch we touch in ambulatory care, and you can do so much more if you deploy the services that way.

Now, one more frame of reference for whether we are doing a good job: we are providing about 400 outpatient visits per 1,000 veterans for our entire catchment area. The VA average is over 800. The Sun Belt major metropolitan areas approach 1,000. It is in the rural areas, by and large, that we're dropping down to 400 and 500, but not the rural areas that have a VA hospital. It was 200 in Redding before we put the clinic up there. It is about 400 now.

Until we begin to deploy our resources to some degree based upon capitation, we're not going to be serving the rural veteran. The rural veteran that has a VA hospital nearby is going to get service, but the rural area that does not have a VA hospital is not going to get service. It is as simple as that. The service follows the dollar.

Mr. STEINBERG. Mr. Daisey, do you want to respond to the issue of major obstacles that you face in providing counseling and how well you think you're doing given the enormous size of your catchment area? I think you sort of touched on that earlier.

Mr. DAISEY. Yes. And I have to ditto what other people are saying. The problems we face are certainly the distances, the fact that you have close communities, and the lack of skills in the professions to provide these services. But I guess the one that keeps me awake at night and probably keeps my colleagues awake at night, especially when you're dealing with the fact that many of the people that I deal with are entitled to the services, is a lack of resources. That's the problem that I think we face.

What is going on in rural areas for Vietnam veterans is similar to a system that was developed in battlefield conditions. It is a triage system that one has to decide who is so sick that they're going to die anyway, so you put them to one side; you have to decide who is sick but may be able to survive without the services; and you have to decide who needs those services in order to survive. Those are the people that you have to give the services to.

I guess that, for me, is the biggest problem that I face. The one that keeps me awake at night is having to make that decision. How are we doing with that? It's not that I don't think we're doing a good job with the resources we have. I think we are. But I think there is more that we need to do. I think we need to expand the resources. I think we need innovative ideas, as people were talking about today, to start coping with it and dealing with it differently so that we are not faced with having to do a triage for eligible veterans.

Mr. STEINBERG. Moving on to another question now—and we'll start with Mr. Andries in the middle and radiate from him—in VA's prepared testimony several mechanisms for reaching veterans in areas remote to VA facilities were mentioned. How useful and how available have strategies such as mobile clinics, community-based or satellite facilities, outreach clinics, or other methods been to your facility and to the veterans you seek to serve?

Mr. ANDRIES. Right now we have one outreach clinic. It is a small operation in Torrington, WY, which is approximately 110 miles from the VA. Basically, monthly, a nurse practitioner and a MAS person drive up there for a day. The majority of the time they are in the car driving there and they see nothing, and when they get there the patients come.

Now, in our strategy we feel it is much better to move maybe 25 miles further to put a small, six-man presence in the Nebraska State Veterans' Home so that we could have it on a continuous basis.

In Wyoming it is my experience that mobile clinics don't work, basically because as you drive around there is nothing there for long distances, so most of your time is spent driving. The cost effectiveness of the mobile clinic is just impacted. When you go from Cheyenne to Casper it is 185 miles center to center. There are two little, tiny cities between that and a whole bunch of missile sites.

Mr. STEINBERG. Unless you have a veterinarian on board there's not much business.

Mr. ANDRIES. Right. But what I'm saying is that if we put—and we have charted it out. If we put an outreach clinic in Casper, one in Scottsbluff, and one in Riverton Lander, where the reservation is, everybody is within 100 miles. In Wyoming, driving 100 miles is not considered a big problem. You do it to go to the grocery store. That is much more effective because it will be there more times.

Ideally, what you are treating in an outreach clinic is normal, everyday, doctor's office type of treatment. But occasionally you will get an emergency, and you've got to do something then. In the places where we can put one, there are facilities to treat an emergency.

When I first got there, one of the issues was to tell people about the VA. We went to the Salvation Army. Once a month they hand

out excess agricultural commodities, and we set up a clinic to meet with people and to do a screening physical on them. We had two people going through heart attacks at the time we were examining them. If you have a mobile clinic that can happen, and you're 120 miles away from any health-care facility, you've got a major problem on your hands. At least when the people come to us we will have the facilities to take care of that.

So I think the other issue is the question of supervising the quality of the care that we provide in these areas. I think that is an issue. You have to have the ability and the backup. I think that we can very conveniently—again, working together with other agencies—provide that type of quality control.

One of the things that we were told when we examined Farmington, the very difficult problem—and I don't know if Redding is this way—is that it is hard for representatives of the hospital to drive up there on a periodic basis. It is an issue. What you want to do is to build in a quality control mechanism at the site so that you can watch it.

Mr. STEINBERG. Doctor Goldstein, could you respond to that same question, please?

Dr. GOLDSTEIN. Yes. I want to agree entirely with Mr. Andries' comments. Mobile clinics have a lot of problems. Would you want your doctor to be available once a week for a few hours to have essentially a couch and a stethoscope and no access to radiology and laboratories? That's not what medicine is about these days. Medicine is not transportable. Now, some of it may be, but we're talking about delivering health care to very sick people. These are not well baby clinics that we're doing; these are people with cancer, end-stage lung disease, end-stage renal disease, chronic congestive heart failure. They deserve better than that.

Mr. STEINBERG. How about community-based or satellite?

Dr. GOLDSTEIN. There are a lot of innovative things that are going on. Outpatient clinics are a different story. The VA, especially in the Southeast, has gone into outpatient clinics in a big way. I guess they have done so in California, as well. Again, though, an outpatient clinic requires a certain population base to make it cost effective. We have counties in our State that have less than 500 veterans. It would be hard to justify spending $1 million a year to put a clinic there when that same $1 million could be given to the medical center and upgrade services that are readily available to 30,000 or 40,000 veterans. It is a difficult question to answer when resources are tight.

But we have to be careful. Let's not go to second-rate medicine. Whatever we do—there are lots of possible solutions out there—let's not cut the quality or give up on the quality just so that we can go from 400 visits per 1,000 to 500 visits per 1,000. That's not worth the effort.

Mr. STEINBERG. Mr. Powell, would you like to add something on this issue, please?

Mr. POWELL. I agree with Doctor Goldstein. The VA at Beckley does not have any outpatient clinics out in the community; however, there are things that we can do to assist veterans without putting clinics out in the community. We can develop hospital-based home care programs where a social worker and a nurse go out and

provide services. I'm not sure it is cost effective to send doctors all over a rural area just to provide one or two patients care. However, it is cost effective to send a social worker or a nurse that can make assessments and get the patient back to the primary care giver.

I think that's what we have to look at—alternatives other than just putting clinics out any place. There are other ways to address the problem.

Mr. STEINBERG. Clarence, do you want to respond to this? Of course, you have already described the Redding clinic, but there may be other strategies that you may want to address, and you may want to address the mobile clinic issue.

Mr. NIXON. I have two points. Number one, I wanted to endorse what they said about mobile clinics. We looked at mobile clinics. Having one clinic in Redding was not all we looked at; it is what we decided upon because of the large population. We had to have a more substantive capability up there.

But we looked at part-time doctors hooked up with other private doctors out in eight or nine counties. We looked at mobile clinics. We discarded those as not viable and dangerous in terms of what it would do to the quality of the care that we provide in this agency if we moved in this direction.

Now, that's not to say that community-based clinics can't work in real sparse areas that are highly isolated.

Mr. STEINBERG. I believe your regional director was one of the innovators of mobile clinics way back when he was in Salt Lake, and I'm not sure whether those are still going on at this time.

Mr. NIXON. I'm no expert on it. We have not had mobile clinics. We have had a lot of experience with ambulatory care, and we explored as many options as any facility in our system has. We discarded mobile clinics because of the quality, the control, and the cost effectiveness because of the distances involved.

Mr. STEINBERG. Mr. Daisey, why don't you adapt that question to your particular experience and service responsibilities?

Mr. DAISEY. As with the mobile clinics I have no experience. They are not utilized in the State of Maine right now.

Certainly there is a diagnostic clinic that has been opened in Aroostook County—a medical clinic.

Mr. STEINBERG. We're very familiar with that.

Mr. DAISEY. It has been very, very, very successful. I think it may be what you were talking about. In that sparse area where there really are no services, this has really helped. It has really helped the veterans. Many veterans who have been actually eligible for service and never knew had never, never utilized these services.

Mr. STEINBERG. Senator Mitchell worked very long and hard, as you know, to achieve that diagnostic clinic.

Mr. DAISEY. Yes. Of course, in my area of expertise this clinic, of course, does not provide readjustment counseling services or any psychological services. It is a diagnostic medical clinic. But I think it has been very helpful for a lot of the veterans that we serve and has given them some hope, too, I think, that they are at least not forgotten up in the rural areas.

Mr. STEINBERG. Let me now cover a couple of subjects that Senator Rockefeller covered with Mr. Powell already—and let's try to

keep the answers, at this point, as brief as possible. We'll skip you, Mr. Powell, since you have already answered this. We'll start with Doctor Goldstein.

Could you describe the typical family that is receiving respite care and the importance of respite care services to the veterans and families in question?

Dr. GOLDSTEIN. It will be a very brief answer. We have no respite care program in South Carolina.

Mr. STEINBERG. That's a very brief answer.

How about you, Mr. Andries?

Mr. ANDRIES. We started a respite program last year. In fact, it is the purview of our assistant chief of nursing, and it has been tremendously successful.

The typical family is a family with a veteran who has a long, debilitating disease, who is generally a category A veteran whose family has chosen to take care of him, who can take care of him, and we bring them in for a period of a week and give them a break.

The letters we get from it—and it is very small. I'll have to get you the information on the exact numbers. It is tremendously successful. Without this, some people would have to be brought in. The family would just burn out. I think it is a tremendously effective and cost-effective program. I can't say enough about it.

Mr. STEINBERG. Clarence?

Mr. NIXON. About the same at Martinez. We have no formal respite care program, but we work real hard to get those veterans out of the hospitals and to keep them in the home. We don't hesitate for a moment to absolutely assure an elderly spouse or working children of an older veteran that we are there. They take the veteran, and we give them the same guarantee we give the nursing home: you get in trouble, you bring that veteran back. If you're ready for a vacation, we'll see that you get a respite from this care either by bringing the patient back in or putting him in a nursing home or doing something. We have a home care program, and that's also hooked in with the home care program, as well.

Mr. STEINBERG. I don't know if you have information on this?

Mr. DAISEY. No, I don't.

Mr. STEINBERG. Let me move to another question that Senator Rockefeller covered with Mr. Powell. Do any of you have a sense as to whether or not veterans coming to your facilities without health insurance are an increasing number? Mr. Powell said he was going to try to get that information for the record. Let me start with Mr. Nixon on that.

Mr. NIXON. I don't have firm data stored back in the back of my mind on this.

Mr. STEINBERG. Will you try to provide something for the record?

Mr. NIXON. Yes, I will. I will try to provide you a more informed opinion in writing.

Mr. STEINBERG. Why don't we just assume that none of you came equipped with that figure.

Dr. GOLDSTEIN. I don't think the agency has been collecting that data except for the last 2 or 3 years. We haven't been asking veterans if they have health insurance. It will be hard to get.

Mr. STEINBERG. You have been collecting for third-party reimbursement since 1986. I think that's right. And so we may have data for 3 years or so, and if you could give us some information, Senator Rockefeller is very interested in whether or not we have an increase in the number of veterans seeking care at VA facilities who do not have health insurance. That would be very helpful and we would appreciate that.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

As indicated in earlier testimony the VA Medical Center at Beckley has been a decrease in the number of nonservice-connected veterans with private health insurance. During fiscal year 1988 we filed for reimbursement from private health insures in 353 nonservice-connected cases, while in fiscal 1989 we filed for reimbursement in 334 nonservice-connected cases.

Mr. STEINBERG. Another question Senator Rockefeller pursued with Mr. Powell was whether or not you believe that veterans in rural areas are reluctant to come to VA facilities. And, if so, what is the cause of that reluctance? I think that maybe Mr. Daisey can comment on that from his standpoint, and then we'll work back from him.

Mr. DAISEY. Certainly I think there has been a reluctance for veterans to come forth for help to VA facilities. I think there is probably a reluctance for them to come forth to any facility, but I think for many of them dealing with readjustment issues there is some basic mistrust not just of the VA system, I think, but of the whole Governmental system and maybe of the country.

I think in the last 20 years, just as the United States has come to grips with and is starting to incorporate those issues, so have the veterans. I do see the mistrust is diminishing as the country, I think, becomes more accepting.

Mr. STEINBERG. That was, of course, a major mission of your program, wasn't it?

Mr. DAISEY. Yes, it has been. And although it continues, I see some areas of trust increasing. I think, of course, when we're talking about rural areas one of the things you have to remember is that there is mistrust of VA as there is mistrust of any system. I have found that people in rural areas trust people; they don't trust systems. If they know the person, whether he belongs to the VA or he belongs to DHS or whatever organization, if they can trust him, the system really becomes irrelevant. But it is getting to know the person, I think. It is a very personalized thing in a rural community.

Mr. STEINBERG. Clarence, would you like to comment on the reluctance question? Of course, I guess Redding has given you some readily transferable data in that area.

Mr. NIXON. I think that the reluctance to the degree that it exists is going to be based on a number of variables. I do believe that veterans, based on these variables that apply to their daily lives, do get conditioned to a certain level of expectation from the VA.

If you are in an area where most of the veterans are located fairly nearby and the perimeter of your catchment area is 75 to 100 miles, geography is not going to make a veteran reluctant to come. But if there are 2 million veterans in that area they are going to

get conditioned to what is happening at the front door of that hospital.

With regard to the trust factor, I think you can talk about trusting the VA only at the national level. I think when you get down to the veterans' daily lives that it is not a matter of trust but it is a matter of the image of the local VA hospital. Believe me, VA hospitals' images do vary from one to another, and I think they are critically important. There are, again, many things that create that image.

I think the veterans do get conditioned by many things, but I don't think that there is an ingrained reluctance to come for any one, big reason.

Mr. STEINBERG. Mr. Andries?

Mr. ANDRIES. I'm almost scared to say this, but, as I said, the use of our hospital in 3 years has grown by 44 percent. I think that we have people that like to use us.

Another example is the fact that the Wyoming Hospital Association supports us because we really are part of their health-care system. Yet, in Cheyenne they had a problem of out migration, and we're the only hospital in town that has growth with people coming to us.

I agree with Clarence and everybody else. The issue is the local hospital. It is how you relate to the individual local person. It is how the clerk at the door treats the person when he comes in and listens to him.

I feel very strongly that our number one strength, if there is one in a small, little, tiny hospital in rural Wyoming, is that fact that our people care and project that to the veterans, and that's returned by them coming there. That's an intangible and you can't address that, but you can feel it and it really is something that is important.

I think that the people in Wyoming trust the VA if they need to use it.

They are also very independent people and they won't necessarily use it unless they absolutely need it.

Mr. NIXON. Could I add one thing to his point?

Mr. STEINBERG. Please do.

Mr. NIXON. I think the greatest positive feedback that I have gotten in the years that I have been at my present assignment is the fact that—like you said, they don't use it very often, but I'd say every veteran that uses our facility and the people that relate to it know that management is available if an unhappy veteran or a relative has a problem. You don't have to run a gauntlet to get in to see the chief of staff or the hospital director.

Mr. STEINBERG. Doctor Goldstein?

Dr. GOLDSTEIN. Yes. I want to echo what has been said. I think it is an individual image type of problem. I'd just add that I think we have two populations: we have one population of highly entitled veterans who get lots of good care from the VA and who truly like the VA and who will speak well of us; and then we have a second population of people who, for the last 2 or 3 years, we've been telling to go away and not bother us. We really can't expect those people to embrace us with open arms. We're developing an image problem among a certain subsection or subset of veterans, I think.

Mr. STEINBERG. Mr. Powell, we'll start with you now. You've been silent for a while. How do you think the recent VA budget crisis—which we all understand is not over—has affected your facility's ability to serve veterans who live significant distances away from your facility?

Mr. POWELL. The crisis affects all veterans the same way. It doesn't make any difference whether you are a long way away, other than the travel aspect of it.

Mr. STEINBERG. Well, has it, for example, caused a reduction, whether authorized or not, in beneficiary travel? That's one result that can occur.

Mr. POWELL. That is a result—I believe there is a 30-mile radius in which the veterans won't get paid for travel; however, we have tried to address that issue at Beckley by working with the Disabled American Veterans of West Virginia by setting up a transportation network.

Mr. STEINBERG. Is that working well?

Mr. POWELL. It works very well. We're able to supplement some of the veterans that live within the 30-mile radius. We give them the travel pay through DAV, and we provide transportation for individuals that would have no other means of getting there.

The VA can't do everything for everybody. It has got to be a joint, cooperative effort. The service organizations help. The States can help. We need to coordinate our system. We can't just say the VA is responsible for everything. We don't have the resources. But there are resources available; it is just coordinating them between the multiagencies that are involved in health-care delivery.

Mr. STEINBERG. Doctor Goldstein and any of the others, do you have any particular sense that the problems for veterans who live long distances have been made worse as a result of the budget crisis?

Dr. GOLDSTEIN. Well, they certainly haven't been made better. I think we have heard a number of solutions and innovations that people have tried, and there is a lot more that can be done. We run a van and we go pick up veterans.

Mr. STEINBERG. Excuse me, if I may interrupt a moment. Isn't there a sense in which when you are in a budget crisis such as we have been in for at least 18 months—and Dr. Winship suggested earlier that it really was going on before that, but it wasn't fully recognized until 14 or 15 months ago—that things that are not perceived as core responsibilities tend to get hit pretty hard when dollars get tight? Maybe you disagree with that hypothesis.

Dr. GOLDSTEIN. I would disagree with that. I think that medicine is ever changing and ever revolutionized, itself, quicker than the Federal budget does. Everybody tries—I think a budget crisis backs you into a corner and forces you to try different things and it forces you to look at your priorities and to look at what you're doing and what you're not doing and try something new and different. I think we've heard some new things and some different things that have been tried.

So, in a sense, there have been some experiments that have grown out of this, but there is a lot more that can be done. There is a lot more that needs to be done.

Mr. STEINBERG. Within the resources that you have available.

Dr. GOLDSTEIN. No. Within the resources that you're going to add to those resources. That's the one message I've been told to say. Never accept anything within existing resources; always say you need additional.

Mr. STEINBERG. We're trying our best, fighting against enormous odds, unfortunately.

One generalization I have found true about VA in the many years that I have been involved with it is that you can't generalize about VA facilities. It is very hard for people that haven't been involved with the system to understand that. Although there may be many areas of common experience among the five of you, and there is supposed to be a commonality of experience as to rural veterans, I think you would find out that you have at least as much not in common as you have, at least as relates to your particular local, State, and regional characteristics, in common. So with that little speech, I'll yield to Mr. Andries.

Mr. ANDRIES. If I understand the question——

Mr. STEINBERG. Has the budget crisis had a disproportionate effect on services to rural veterans—veterans who live a distance——

Mr. ANDRIES. I think so. Yes. I'll tell you why.

Mr. STEINBERG. You think the answer is yes?

Mr. ANDRIES. Absolutely. We have, over the last several years, been on the list—I was asked never to use acronyms, so the Medical District Initiated Planning Process. We were scheduled to have two initiatives from that.

Mr. STEINBERG. Now, we're going to ask you never to use long names.

Mr. ANDRIES. All right. One was to fund a mental health clinic, which they had never had in Wyoming. It got up to fourth or fifth on the regional priority list, and then the budget crunch hit and it disappeared.

We also had a Casper clinic that was to be funded by the region—high priority. The budget crunch hit and it disappeared.

The problem is that we have been trying to plan things to address them. You are absolutely right. As the budget crunch hit and we diverted nonrecurring money from projects to keep the base camp operational, as the gentleman from Togus said, we have given up all hopes of funding planning. You can't have planning and keep bright minds continuing to plan and develop ways to do things if you can't occasionally put some resources with it. That's where we are hurt.

We are a little bit luckier in Cheyenne. We have a major construction project that is coming online. We came within 1 month last year of not making it to that construction project. That's how tight it was. And we've had to divert things.

What we have done is ratchet down and make ourselves more efficient. We have finally eliminated every other pot there is, and we're basically in a survival mode. That means anything that isn't built now probably won't have funds to get to it because we are in a survival mode. I think that's the issue. And rural health has not been addressed in the past, and so it is a new thing. The only way you're going to fund it is to take away from something that is already existing. So I think it has impacted on us.

Mr. STEINBERG. Clarence, perhaps you'll give an in-between answer.

Mr. NIXON. Well, I don't think in this case. I will just present it a slightly different way.

I think a 60 percent service-connected veteran that was shot in the heat of battle with multiple wounds that lived 5 miles from a VA hospital and is well employed, like everybody else has certain barriers to care. He has got to get up and work. He's got to make decisions.

The other end of the spectrum is the veteran in Montana that is located 400 miles from the VA hospital, is not service connected, low income, and got a $40,000 tractor.

Everybody has barriers that they have to overcome to get care in a VA hospital. As things start to tighten up, it makes those barriers greater for everybody.

Now, the rural veteran started with greater barriers, so yes, he's going to be more affected by it.

With regard to how cutbacks affect a VA hospital from a systemic point of view, I think an organization is like the human organism. You have to maintain a certain functional level for the vital organs. In management and in data we refer to that as a critical mass, I guess.

So there are certain basic functions within an organization that have to be maintained at a certain level, and if it is an organization that is sort of on the cutting edge of the resource problem already, then what starts happening in the clinics and at the front door is going to be affected, but the laboratory service and the surgical service and the radiology service has a certain floor under them. You can cut them down only so far, so you begin to lose economy of scale.

In both of your questions, yes.

Mr. STEINBERG. Mr. Daisey?

Mr. DAISEY. Yes. I would have to agree with Gary Burns who had mentioned earlier from DAV at Togus that they have closed down an acute psychiatric ward. They've closed 20 beds of an alcohol unit. They have shut down a medical ward. I agree with Mr. Nixon. I think the barriers grow. For someone who is living 200 miles away and needs alcohol rehabilitation and comes all the way down and gets told they will be put on a waiting list and have to come back, the chances of recovery are now much slimmer and those barriers are now much higher for him. As they have raised for everybody, they have raised for him on the same level, but now they're higher.

So I would agree that it has had an affect and has really cut our base. At Togas, certainly, those services are affecting the veterans that I deal with—the lack of those services.

Mr. STEINBERG. The next question I'm going to ask you is to be provided for the record along with the information that you're going to give us on veterans with insurance. Please describe the non-VA resources that are available in the catchment area that you serve for the veterans that are particularly geographically distant from your particular facility. That will give us a sense of how you fit into the overall health services picture in your catchment

area. But particularly focus on those veterans who are particularly distant from the facility.

If you'd provide that for the record, we'd appreciate it very much.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Southern West Virginia has been very fortunate in attracting rural health clinics under the Department of Health and Human Services, section 330, which provides a funding source for rural health clinics. Ten of the 11 rural West Virginia counties in our catchment area have clinics under this program. These clinics can provide outpatient followup and medication to individuals at a reduced rate based on income. The clinics do provide some assistance to our veterans in our remote rural counties. Unfortunately, some physicians in these clinics do not have admitting privileges in local community hospitals. In addition, some clinics are located in rural counties without hospitals. In the above cases the veteran is often totally dependent on the VA Medical Center at Beckley for inpatient care.

We have in our rural catchment area a totally inadequate mental health system. Each county has a mental health clinic however per our contact with the agencies they are understaffed and underfunded. They view the Va Medical Center as a resource and usually refer veterans to our facility for treatment.

We have a number of high quality nursing homes that provide excellent care in our catchment area. The availability of beds is sufficient for patients not needing specialized services. If however, the veteran is respirator dependent or a geropsychiatric (Organic Brain Syndrome, Alzheimer disease, or the chronic elderly psychiatrically impaired individual) patient there are no acceptable community alternatives. The State Hospitals which provide care for the geropsychiatric patients are often filled. The community mental health centers in our area are not able to provide sufficient supervision of geropsychiatric patients on a outpatient basis to maintain them in their home communities. Veterans needing geropsychiatric care have few options, and VA in many cases is the only agency that can provide some assistance through our respite care program or intermediate and geropsychiatric programs. However, in southern West Virginia we do not have a Geropsychiatric Unit, patients must but transferred to VA Medical Center in Salem, Virginia for long term care. The VA Medical Center at Salem now has an extensive waiting list for this type of care.

The respirator dependent veteran often has no resource other than continued VA hospitalization. Private nursing homes in our catchment area will not accept ventilator dependent patients. Private nonfprofit and for profit health care centers in our rural area look to the VA Medical Center at Beckley to admit veterans from their facilities who are stable but ventilator dependent when they have exhausted their private insurance. In general, chronic care patients that are not money winners for private facilities under the Diagnostic Related Group reimbursement model often suffer due to restrictive monetary policies. Veterans, many of them elderly World War II and Korean War era, find that the private rural health care system is not able to meet their chronic health care needs. The VA Medical Center at Beckley is looked upon, by these veterans as the agency that provides the major portion of the health care services available to them. Without continued availability of the wide array of VA Medical Center inpatient and outpatient services many veterans would not receive the care they need in our area.

Attached is a list of the hospitals and mental health centers that exist within the counties in our current catchment area. As far as Wyoming is concerned, the Wyoming Hospital Association has indicated that statewide, Wyoming hospitals have operated with a negative operating margin for the past 2 years. Veterans falling within the income guidelines of category A level and who have been unable to utilize VA facilities because of distance, have continued to place a great financial burden on this already overtaxed health care system. As far as mental health is concerned, in the entire State of Wyoming there are only 18 non-Federal psychiatrists. Of this number only 12 are within our current catchment area. The availability of mental health services is extremely limited in both the private and public sectors.

HOSPITAL FACILITIES WITHIN CHEYENNE VA, CATCHMENT AREA

The eight (8) counties in Nebraska have six hospital facilities available. The furthest from Cheyenne is 170 miles—the closest is 60 miles.

The 10 counties in Wyoming (excluding Laramie County) have 14 hospital facilities available. The furthest from Cheyenne is 342 miles—the closest is 49 miles.

WYOMING HOSPITALS IN CHEYENNE VA CATCHMENT AREA

Albany County: Laramie (49 miles)—1 communty hospital, 110 beds (99 acute care, 11 long term).
Carbon County: Rawlins (149 miles)—1 county hospital, 99 acute care beds.
Converse County: Douglas (129 miles)—1 county hospital, 44 acute care beds.
Fremont County: Lander (272 miles)—1 regional medical center, 107 acute care beds; 1 private facility (Pineridge Hospital), 48 acute care beds.
Riverton (270 miles)—1 community hospital, 70 acute care beds.
Goshen County: Torrington, (84 miles)—1 community hospital, 68 beds (53 acute care, 15 swing).
Hot Springs County: Thermopolis (309 miles)—1 county hospital, 49 acute care beds.
Johnson County: Buffalo (290 miles)—1 county hospital, 43 beds (29 acute care, 14 swing).
Natrona County: Casper (178 miles)—1 psych and chemical dependency, 54 acute care beds: 1 medical center, 282 acute care beds.
Platte County: Wheatland (70 miles)—1 county hospital, 172 beds (43 acute care, 43 long term care, 43 swing, 43 nursing home.
Washakie County: Worland (342)—county hospital, 60 beds (30 acute care, 30 swing).
Fremont County: Ft. Washakie (270 miles)—1 Indian Health Services (IHS) Outpatient Facility.

MENTAL HEALTH CENTERS SERVING CHEYENNE VA CATCHMENT AREA

Carbon County Counseling Center, Rawlins, WY.
Central Wyoming Counseling Center, Casper, WY.
East Wyoming Mental Health Center, (Serving Douglas, Lusk and Glenrock, WY).
Hot Springs County Counseling Service, Thermopolis, WY.
Southeast Mental Health Center, (Serving Cheyenne, Laramie, Torrington, and Wheatland, WY).
Washakie Mental Health Services, Worland, WY.

NEBRASKA HOSPITALS IN CHEYENNE VA CATCHMENT AREA

Banner County: No facilities.
Cheyenne County: Sidney (103 miles) 1—private hospital, 131 beds (63 acute care, 69 long term).
Deuel County: No facilities
Garden County: Oshkosh (159 miles)—1 county hospital, 60 beds (20 acute care, 40 convalescent).
Keith County: Ogallala (170 miles)—1 community hospital, 49 acute care beds.
Kimball County: Kimball (64 miles)—1 county hospital, 30 acute care beds.
Morrill County: Bridgeport (143 miles)—1 county hospital, 23 acute care beds.
Scotts Bluff County: Scottsbluff (115 miles)—1 regional medical center, 191 acute care beds; 1 Outpatient Mental Health Center (Panhandle Mental Health).

Mr. STEINBERG. Now, I'll start with Dr. Goldstein. Are veterans in your catchment area—and you can answer this question, I hope, briefly—worse off, better off, or approximately the same in terms of access to medical care than are nonveterans?

Dr. GOLDSTEIN. That's a hard question to answer because the population of our State, as a whole, is not very well off. Every county in the State is classified by Health and Human Resources as being a medically underserved area. I think 80 percent of our counties have some classifications from the Public Health Service as being doctor shortage areas, as well. So the baseline situation is not very good.

I think that veterans have at least one thing going for them. They have a safety net. If nothing else, any veteran who can manage to overcome the obstacles—and there are lots of obsta-

cles—and show up at the evaluation clinic desk will get seen and will get some level of care, whether it is urgent care, whether it is hospital admission, whether it is nursing home care, or whatever. There is this safety net that exists.

Mr. STEINBERG. Do you think nonveterans have that safety net?

Dr. GOLDSTEIN. Not in our State.

Mr. STEINBERG. So you're suggesting that veterans may, in that respect, be better off.

Dr. GOLDSTEIN. In that respect they are. Now, in the respect of if you are going to compare our veterans to someone who has a high level of private insurance and has access to the medical university hospitals and the cardiologists and cardiac surgery, I think there are a lot of services that are not available to our veterans that are available to people who have insurance or other resources. At least we're there. If all else fails and the veteran can get to us, we'll take care of him.

Mr. STEINBERG. Do you think that veterans, in terms of access to care in VA, are better off or worse off today than they were 4 years ago?

Dr. GOLDSTEIN. I think we've cut out a lot of veterans in the last 4 years. We've rejected a lot of people.

Mr. STEINBERG. Do you think they are worse off?

Dr. GOLDSTEIN. A certain subpopulation of veterans definitely has been denied care in the last 4 years.

Mr. STEINBERG. Let me turn to Mr. Powell now and ask the first part of that question. Do you think that veterans' access to care is better, worse, or about the same as nonveterans in your area?

Mr. POWELL. If you are a category A veteran, if you are service connected, and you have a limited income, you have better access. If you are a category B, which is sort of a fall-between category, it is the same. If you are a category C, you probably have health insurance, so it is available to you out in the community.

I think we seriously have to look at category B patients. The income limits are insufficient for them to support their health-care needs. A nursing home care bill can run anywhere between $2,600 and $3,000 in our particular area. Those individuals just can't manage that, and so they just don't receive any care when they need extended care.

Mr. STEINBERG. How about the second part of the question? Do you think veterans generally, in terms of access to care, are better off or worse off today than they were 4 years ago?

Mr. POWELL. At Beckley we do have some problems retaining certain specialists. With the cap on salaries, certain specialty physicians won't come there. We need a nephrologist.

Mr. STEINBERG. Was there a nephrologist 4 years ago?

Mr. POWELL. Yes.

Mr. STEINBERG. So in that sense, the veterans who need that sort of care are worse off?

Mr. POWELL. Yes. We have to use a consulting physician now to keep that unit open.

Mr. STEINBERG. Let me move to Mr. Daisey on this question. I have to assume that I know the answer to this question. Veterans are much better off than nonveterans in terms of the availability of readjustment counseling.

Mr. DAISEY. Right. I would agree with that.

Mr. STEINBERG. We could assume that's quite clear. And I think that's one of the unique and particularly valuable aspects of VA's medical system that exists, and nowhere is it more apparent—I'm sure Mr. Nixon would attest to this—than in the San Francisco Bay area now where 8 or 10 vet centers in the Bay area—I've probably overestimated it, it may be six—are contributing to the community very substantially in terms of a specialty that they've quickly acquired called "post-earthquake traumatic counseling." That's absolutely true, and they are contributing large chunks of time to the readjustment of the community to life as normal, if that term has applicability.

But do you think on the second part of the question, from the standpoint of veterans needing readjustment counseling, are they better off or worse off in terms of being able to get it in Maine today than 4 years ago?

Mr. DAISEY. I think in some aspects yes, they are better off. But if you look at readjustment counseling, of course, and the readjustment issues as just being part of a whole, and the person isn't just this Vietnam veteran dealing with readjustment issues but other issues, too, that may be inter-related—both physical and psychological—other services are going to be needed. So as those services are cut back at your base, or are no longer available, then he is worse off.

So in some aspects, as far as receiving the counseling, itself, probably better now than it was before. There was very little being done except when I was doing it up in the county when I lived up there for about 9 years. There is probably more going on just recently now than there was for quite a few years as far as giving the actual services. But there are aspects of it that have certainly diminished—alcohol rehabilitation has been less available to the veterans, acute psychiatric has been less available, and even medical care. That has really affected them, too.

Mr. STEINBERG. When those sorts of services are not available in the medical area, that impacts on the trust factor in terms of your ability to get people to come into the system and trust the system, I think.

Mr. DAISEY. Right. And a lot of times people don't survive that. They end up either being State institutionalized or going through alcohol rehabilitation in jail. You can't give them the treatment then. So it is not just the trust factor. Some people just don't survive it when the services are cut.

Mr. STEINBERG. I think one piece of good news, if I am correct, is that there is about to be a PTSD treatment team located, we hope, in Togus with some of the $6 million that Congress has specifically appropriated for new PTSD treatment teams. I think there are to be 20 new PTSD treatment teams. I know that Togus has been seeking one for quite some time and Senator Mitchell and, I'm sure, Senator Cohen have been working very hard to bring that about, and perhaps that relief will be available.

I'm going to ask you each if in 30 seconds you have any particular thoughts you want to leave with the committee in terms of getting back to our basic theme of what is the single most important

thing, in your judgment, that needs to be done to improve care for veterans in rural areas. We'll start with Mr. Andries.

Mr. ANDRIES. Thirty seconds or better?

Mr. STEINBERG. You could do it in 25.

Mr. ANDRIES. I think we have to have flexibility, as you said, to address the individual issues that are out there. We have to have flexibility to work with other agencies that are interested in health to develop a cohesive whole, and I think that's really important. Working together, we'll create a better product. If, for example, we establish a family practice clinic residency and we help fund half of it and they help fund half of it, we're going to get a tremendous benefit that is much more than our investment in it. If we can get the Air Force to use their Med Evac system and not fly over the top of us, we can get people conveniently between Sheridan for their surgery and our psychiatric patients back without driving them all over. We can improve things.

The issue is working together and having the flexibility to work that out at a local level. I think that's my number one issue that we have to have. If we have that flexibility and the resources that go with it, we can improve the issue.

Mr. STEINBERG. Dr. Goldstein?

Dr. GOLDSTEIN. Well, you know we need resources. My outpatient doctors see 40 patients a day. That's the limit of what they can do and do a good job. I can't increase my work load.

I'm fascinated by the survey of veterans that I cited earlier. I think one of the things that we might want to do before we go out and spend a lot of money hiring doctors and buying vans and contracting doctors on a fee-basis is go out and talk to our patients and tell them who we are and tell them what we do and show them these wonderful medical centers we have built, tell them about the DAV, tell them about beneficiary travel, tell them about all the things that we have. Maybe we need just a little information and a little reaching out to people. Something as simple as that could help a lot of people.

Mr. STEINBERG. Mr. Powell, your 30-second conclusion for us?

Mr. POWELL. The VAs are a major component of the rural health-care system. I think we need to make sure that our community-based programs are properly funded. The contract nursing home programs need to be protected. We need to reach out and have joint ventures such as our transportation network that has evolved in Beckley, and we need to continue to develop the innovative inpatient programs that the VA is known for like respite care and intermediate medical care. With these, the veterans will get the care they need.

Mr. STEINBERG. That's a very effective summary in less than 30 seconds, too.

Clarence, I think that I failed to let you respond to the preceding question. Am I right?

Mr. NIXON. That was on access? I'll respond to it very quickly.

Mr. STEINBERG. Nonveteran versus veteran access as to being worse off today, and then whether veterans' access, in general, was worse off than 4 years before.

Mr. NIXON. OK. Let's start with veterans versus nonveterans. I think it is hard for me to answer that question because I see veter-

ans as citizens, too, and they've got to be better off because they have the Veterans' Administration available to them and they still have all the other options that are available to nonveterans available to them, as well. So I think the veteran is better off.

Now versus 4 years ago, if you ask the people at Redding they would be ecstatic. Yes, it is tremendous now. Four years ago it was nothing.

If you ask the people that are closer to our facilities that have been there all along, I don't think that they would see any difference.

I can tell you that they are better off because we are up about 50,000 visits from what we were 4 years ago, and that's not so much—half of that is because of new resources, and the other half is because of a couple of changes in significant jobs. So we're better off.

The one question that relates to this, Jonathan, is that we are not as well-financed for the programs that we are running today as we were 4 years ago. I think that there is a real danger that we will not be able to sustain these.

Mr. STEINBERG. You reopened all of the programs that were closed down in fiscal year 1989?

Mr. NIXON. I have opened everything except a ward that was closed, and that ward should remain closed because those resources are deployed toward ambulatory care where we are getting more out of it for the veteran.

Mr. STEINBERG. Mr. Andries, how about you?

Mr. ANDRIES. Basically I agree. I think for the category A veterans things are better than they were.

Mr. STEINBERG. Have you reopened all of your programs that were closed down?

Mr. ANDRIES. The only thing that we have not reopened—again, like him, we consolidated a ward because we have redeployed resources for ambulatory care. But other than that we have everything back in operation.

Mr. STEINBERG. Doctor Goldstein, do you know the answer to that?

Dr. GOLDSTEIN. We closed a ward about 2 or 3 years ago, but that was a combination of lack of resources and just the nursing shortage.

Mr. STEINBERG. Nothing specific in fiscal year 1989 that was closed?

Dr. GOLDSTEIN. Nothing has been reopened that was closed.

Mr. STEINBERG. Do you know that, Mr. Powell?

Mr. POWELL. We didn't close anything.

Mr. NIXON. Jonathan, we used $2 million in nonrecurring money to keep those things open last year and we are well into the same thing this year the way things are looking.

Mr. ANDRIES. I'd like to say ditto to that. That is actually true. We did divert a lot of nonrecurring money to keep things going.

Mr. STEINBERG. I'm afraid that the talent that each of you has developed for those kinds of diversions is going to be called upon in fiscal year 1990, as well. We have added over $700 million to the administration's budget request for fiscal year 1990. Sequestration is apt to deprive us of something over $50 million of that amount,

which is a lot of money, if sequestration is only in effect for a 2-month period—that is, through the end of this month. That issue is being fought out even as we speak. The administration has requested that sequestration remain in effect through February 1, which would mean it would be in effect for fully one-third of fiscal year 1990, which would cost medical facilities about $85 million. That will break down for each of you into a considerable amount of money, so you're going to need to use those flexibility talents that you have.

Clarence, do you want to give us your 30-second closing going back to our theme of the critical things to keep in mind for most veterans?

Mr. NIXON. Yes. Three things: advocacy—and, incidentally, I believe our Secretary, from what I've been hearing from him, would agree with this. Advocacy is the job of the Oversight Committees, the Department of Veterans affairs, and the veterans' service organization representatives. We've got to continue that advocacy to see that we get our fair share of whatever the Government spending is going to be.

The second one is, as I indicated earlier, I would like to see the VA build in by policy and strategy some aspect of capitation—real capitation--in our resource allocation methodology. Without it we will never get to serving the rural veteran.

The third thing is management and organization effectiveness. We have got to look at how we are managing what we've got and not use all of the regulations and the problems that we have which cause us a lot of frustration, but to not use that as an excuse not to manage, not to take the risk as managers, to get out into the private sector, to share. If it is better to have a community-based clinic based on a sharing agreement, get out there and go for it. If some bureaucrat gets in your way, give him hell. That's what the front-line manager is supposed to do.

Those are the three things I want to see: advocacy, some degree of capitation, and an effort toward real leadership done at the hospital level and at the regional level.

Mr. STEINBERG. I'm going to be talking a little later this afternoon to the Leadership VA group, and, if I may, I think I'll steal your theme and pass that on to them.

Mr. Daisey, you get the last word in terms of the readjustment counseling program. Is there any particular message you want to leave us with in terms of services to rural veterans?

Mr. DAISEY. I think just what Mr. Andries was saying earlier. Part of the focus certainly needs to be in the integration of resources and the community resources that are in rural areas. Training and development of these resources is where I would think the focus should be.

Mr. STEINBERG. Let me close with a few announcements. First, a general word of thanks to each of you for traveling here from literally all around the country. You were a particularly informative and conscientious panel. One reads negative comments—since that is what the press seems to produce—about problems in VA health care. I think all of us who work on this system and the representatives of the Central Office are here should feel great pride in the cross section of committed and dedicated VA personnel that you

represent today. We appreciate the concern and sensitivity that each of you has brought to your testimony and to the jobs that you're doing back in your States.

We regret very much that we were unable to have the Senators present for all of your testimony, but I do want to note that a representative of each of the Senators from the States that you represent has been here throughout your testimony, as well as throughout the hearing—Mary Ella Payne for Senator Rockefeller; Jo Sherman for Senator Simpson; Steve Hart for Senator Mitchell; Kent Talbert for Senator Thurmond; and quite a number of staffers representing Senator Cranston and the full committee staff, as well as, of course, the minority staff with respect to all of your testimony—and as to your testimony, specifically, Clarence, insofar as it affects California.

So we are very grateful to each of you.

I also want to note that Senator Murkowski regrets very much that his schedule prevented him from attending the hearing this morning. He does have an opening statement that will appear at the appropriate place in the record and he will be submitting written questions to this panel as well as the other panel.

[The prepared statement of Senator Murkowski appears on p. 76.]

Mr. STEINBERG. Senator Jeffords is a new but very active member of our committee. He also regrets that he was unable to be here. He has a statement for the record, as well as information that he will be providing from the White River Junction VA Medical Center.

[The prepared statement of Senator Jeffords and information on the White River Junction VA Medical Center appears on p. 78.]

Mr. STEINBERG. I also want to echo the words of Senator Rockefeller in thanking very much the VA representatives who have remained here throughout the hearing. Those he has already named, as well as John Bradley, Meg O'Shea, Gene Hufford, Bill Jayne, and anybody else who I have failed to mention. We greatly appreciate your bearing with us over this very long morning.

Finally, I want to remind the representatives of Senators who are here that, as Senator Cranston announced, we will have a committee meeting to consider the three pending nominations for Assistant Secretaries at the first vote after 2 p.m. in the reception area off the Senate floor; so we ask you to please alert your Senators to that so we can get a quick quorum and vote those nominees out to the Senate floor.

Again, our thanks to each of you for your presence.

There being no further business, this hearing stands adjourned.

[Whereupon, at 12:07 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

OPENING STATEMENT AT HEARING TO CONSIDER
RURAL HEALTH CARE FOR VETERANS
BY SENATOR SPARK M. MATSUNAGA
Committee on Veterans Affairs
Wednesday, November 15, 1989
SR-418

Thank you, Mr. Chairman. I would like to take this opportunity to welcome our distinguished witnesses and to extend an especially warm aloha to Secretary Derwinski, who has done so much to protect veterans benefits and services throughout the current fiscal crisis. Finally, Mr. Chairman, may I commend you and Senator Cranston for taking an active role on the issue of health care for veterans in rural areas. No one has done more for the welfare of America's rural peoples than yourself.

Mr. Chairman, I will be brief. I merely wish to relate the rural health care experience of Hawaii veterans. As you know, in April 1987, this Committee conducted oversight hearings in Honolulu to examine the adequacy of VA health care services in Hawaii, including services provided in the isolated neighbor islands of the state. It was clear from the testimony provided to the Committee by veterans, health care officials, and others that the medical and psychiatric health care needs of Hawaii veterans in general, and neighbor island veterans in particular, had been seriously neglected. After the hearing and to its great credit, the VA immediately established a special Task Force to assess the issues brought forward at the hearing.

The Task Force, under the outstanding direction of Ms. Marjorie Quandt, who happens to be among today's witnesses, made major recommendations to improve directly or indirectly health care services in the outer islands. They included: first, enhancing the resources of the sole existing VA health care entity in the state, the Honolulu Outpatient Clinic; second, establishing collocated neighbor island primary health care clinics and veterans readjustment centers; and, third, constructing a 165-bed VA medical center in Oahu.

Mr. Chairman, I am pleased to say that the first and second initiatives are currently realities. The Honolulu Outpatient Clinic has been doubled in size and, consequently, is far better able to cope with the medical and psychiatric demands of veterans residing in the outer islands. Of immediate relevance to neighbor island veterans, the VA has also established four collocated "mini-clinics" and vet centers in Kauai, Maui, and Hawaii, all of which are doing overflow business. The third initiative, the establishment of a veterans hospital in Hawaii, has been endorsed by Secretary Derwinski, and initial planning for the facility is well underway. The construction of the hospital in Hawaii is critical to the health care needs of neighbor island veterans because experience has demonstrated that only a full-fledged medical center can attract the resources necessary to maintain rural-based services over a long period of time. These initiatives, taken together, if fully implemented, will go far

towards addressing the many unmet needs of Hawaii's rural veterans.

Mr. Chairman, I've described the Hawaii experience in order to point out to veterans, the VA, and members of this Committee that we must and can be responsive to the needs of all veterans, no matter where they reside--even if they happen to live in the remotest community in the most sparsely-populated island in the fiftieth state. I believe that this goal is achievable, if the political will is there, if veterans are willing to take an active role in voicing their concerns, and, of most importance, if the VA is willing to acknowledge that the right of veterans to services and benefits is dependent not on where they happen to live, but rather on their demonstrated service to the Nation. I am confident that these hearings will help us attain this eminently achievable goal.

Thank you, Mr. Chairman.

# # #

Senator George J. Mitchell
Veterans' Affairs Committee
November 15, 1989

Senator Rockefeller,

I want to thank you for chairing this hearing which will allow this committee to examine various aspects of VA programs to deliver health care to veterans living in rural areas.

Your continuing strong interest in the question of health care for rural areas comes as no surprize given your past activities on this committee and as a highly effective member of the Finance Committee. The same can be said of Senator Baucus and Senator Daschle.

I also want to express my appreciation to the Chairman for agreeing to schedule this hearing which is extremely important for those of us who represent essentially rural states.

Before getting to my statement, I want to express my gratitude for the two Mainers who have traveled great distances to testify at this morning's hearing.

The first, Gary Burns, heads the Disabled American Veterans (DAV) office at the Togus Medical Center. Unfortunately prior commitments kept me from hearing Gary who has participated in several veterans hearings I have held in Maine. He's an exceptionally strong and honest voice for veterans in my state.

The second Mainer, Bob Daisey, a Clinical Coordinator at the Bangor Vet Center will be on the fourth panel. I look forward to hearing from Bob on the particular problems of providing re-adjustment counseling in rural areas.

Mr. Chairman, the focus of this hearing is the access to and quality of VA care for veterans in rural areas. The last time the Committee held hearings on the subject of rural health care was in July 1983.

Interestingly, the subject then was my legislation, S. 523, to require the VA to establish a diagnostic clinic in Aroostook County. For the record, the VA witness at that hearing opposed my bill and indicated VA efforts in this regard were sufficient.

Following that hearing, in section 202 of Public Law 98-528, Congress required the VA to conduct a two-part study of rural health care services for veterans in rural areas.

Part I was to determine the relationship between distance from a VA facility and their use by veterans. In the second part of the study, VA was to recommend an experimental program to provide care in rural areas to be carried out in 5 locations.

In Part I, the VA found that 95-97% of veterans lived within 100 miles from VA facilities and that existing VA health-care delivery mechanisms, such as contract care and fee-basis care, provided reasonable access to many forms of VA care to "all but a few veterans in the most remote areas."

Based on that determination, the VA declined to recommend the pilot program called for in Part II. When informing me of that decision, then-VA Adminstrator Tom Turnage said that a comprehensive study of the "needs of rural Maine, with particular emphasis on Aroostook County, Maine," would be undertaken.

The end result of that study? The VA established a clinic, much like the one envisioned in my original bill at the Cary Medical Center.

I hope that after having a chance to review this morning's record, I will be able to say that things have changed. I was interested to see in Dr. Winship's testimony that over that last four years, VA has activated 111 ORCs or outreach clinics, located in mostly rural communities.

That is a welcome change in attitude from 1983. As I remember the VA's on-going outreach effort then was negligible.

To conclude, Mr. Chairman, this subject is very important. Access to high-quality VA health care should not be limited to those eligible beneficiaries to choose or happen to live in proximity to VA medical centers.

That same sentiment, that all veterans should have equally good access to equally good health-care, was expressed by Secretary Derwinski early this morning. I'm gratified by that statement by the Secretary.

Those of us who represent veterans in rural states have a simple bottom line. That VA should be providing the care to veterans which they need and which they are entitled to under law and which the Department is obligated to provide under law.

I want to again express my appreciation for you chairing this morning's hearing. I want in indicate my willingness to work with you, the Chairman and the Ranking Minority Member, other Senators, and the Secretary to see what can be done to continue to improve VA's performance in this area.

STATEMENT OF SENATOR FRANK. H. MURKOWSKI (R-AK)
COMMITTEE ON VETERANS' AFFAIRS HEARING ON RURAL HEALTH CARE
NOVEMBER 15, 1989 - SR 418, 8:00 am

Good morning ladies and gentlemen and welcome to the Senate Veterans' Affairs Committee hearing on VA health-care services for veterans residing in rural areas. I am delighted that we have such distinguished witnesses to present testimony this morning. I thank Secretary Derwinski for taking time out of his busy schedule to be here today. The Secretary's attendance illustrates his strong commitment to our Nation's veterans.

I am pleased that Senator Rockefeller is chairing this hearing. He has expertise in the area of health care and serves as the Chairman of the Medicare and Long Term Care Subcommittee of the Finance Committee.

I am extremely interested in rural health care issues and I am a member of the Senate Rural Health Caucus. Although it is estimated that over 95 percent of the veteran population resides within 100 miles of a VA facility, a great number of veterans rely on the community for their health care needs. Therefore, when we discuss veterans access to health care we must keep in mind the general condition of rural hospitals throughout the country.

The issues of quality and access to care in rural areas are very difficult. For example, in my home state some geographic areas are simply unreachable except by air. These areas are

truly isolated -- especially when weather conditions do not permit air travel. Afterall, Alaska has a population of less than 500,000 spread out over 591,000 square miles. It is a real challenge to say the least.

There are some very real questions which we face as we address rural health care matters. These questions include:

1) What are the costs of providing services in these areas?
2) How can we ensure quality care is provided when the quantity of services is low?
3) How can we recruit and retain health care providers in rural areas?
4) How can health care providers (VA, DOD, Indian Health Service, and private sector) work together to provide better care in a cost effective manner?

VA has implemented initiatives to expand access to care for veterans in rural areas including establishment of free standing independent clinics and traveling health care teams. Appropriations have been made in the fiscal year 1990 budget to implement a law which provides for mobile health care clinics. I am very interested in seeing the results of this important project.

I look forward to hearing about the programs and approaches taken at VA facilities for outreach and treatment of rural veterans. I hope to have an interesting exchange of ideas on the questions which I have mentioned. I thank the witnesses for their testimony.

STATEMENT BY THE HONORABLE JAMES M. JEFFORDS

BEFORE THE VETERANS AFFAIRS COMMITTEE

ON

RURAL HEALTH CARE PROGRAMS FOR VETERANS

Mr. Chairman, thank you for calling this hearing. Rural health care continues to be of utmost importance to me, not only because of the rural nature of my own state of Vermont, but because it has become a crisis of national proportion.

As you know, Vermont is a rural state with one VA hospital to serve approximately 55,000 veterans. The hospital is located on the Vermont-New Hampshire border. Its service area includes all of Vermont and five rural counties in New Hampshire. I'm proud to say that our hospital is widely regarded as one of the best because of its dedication to serving veterans and its affiliation with Dartmouth Medical School.

However, even with the incentive given veterans to travel to this fine hospital for care, it is often difficult for some veterans to make the trip across the state to use the facility and its resources. For many veterans the needed follow-up visits and outpatient treatments, particularly outpatient mental treatment, is simply not available to them. The cost, inconvenience and time commitment needed to travel to the hospital poses too difficult a barrier to overcome.

Vermont has therefore instigated a creative program designed specifically to address this dilemma. The Veterans Integrated Community Care (VICC) program is an innovative treatment program to provide veterans with outpatient mental health care in their communities. It was developed as a partnership between the Veterans Administration and Vermont Community Mental Health Centers. VA skilled personnel use the local mental health facilities in 4 locations in Vermont and 1 in New Hampshire to provide outpatient mental health services to Veterans in all parts of the state. Since its inception in July 1987, it has served approximately 400 veterans for a total of approximately 9,000 visits.

This program has provided a desperately needed service to veterans-- opening an avenue that might otherwise be closed to them. I would like to ask unanimous consent to submit for the record the information I received from the director of the VICC program, Gary DeGasta, and the creator of the model, Dr. Matthew Friedman. The program is not only cost effective, but is a tremendous way to help those veterans in rural states who need services but cannot afford the time or cost of traveling long distances to receive them. I hope that Vermont's example can be replicated throughout this country.

Medical and Regional Office Center
White River Jct. VT 05001

Veterans Administration

November 13, 1989

In Reply Refer To: 405/00

Honorable James Jeffords
United States Senate
530 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Jeffords:

Enclosed are two articles published in Hospital and Community about our award winning VICC (Veterans Integrated Community Care) program. The program has run twice between 1979 and 1982 and was reactivated in 1987. Its future is uncertain because of resource limitations at White River Junction.

VICC is a partnership between VA and Vermont State mental health resources. VICC clinicians function full-time within Vermont Community Mental Health Centers (CMHCs) while providing service to veterans in their home communities. The details are described in the enclosed articles.

VICC has demonstrated several important points and for that reason is being emulated in other parts of the country:

1. It represents a unique, stable and mutually advantageous collaboration between Federal (VA) and State (CMHC) mental health treatment. Such an integration reduces costs and duplication of services.

2. It reduces barriers to health care unique to rural areas such as: travel distance, travel problems (poor road systems, inclement weather, etc.), time lost from work, limited health resources, and the isolation and social encapsulation seen in rural areas.

3. It provided better treatment and after care at lower cost because of:

   a. lower cost per visit
   b. improvements from treatment last much longer.

These results are detailed in the enclosed article.

4. Patients served by VICC represent mandatory workload (99% Category A). Such patients will not travel long distances to White River Junction (average round trip mileage exceeds 120 miles) but will seek VA treatment when it is established in their home communities.

5. Most importantly, we have learned that when VICC services are discontinued, these Category A patients go without treatment. They utilize neither VA nor local (non-VA) services when VICC is discontinued.

2.

Honorable James Jeffords

VICC is being emulated elsewhere because it makes sense and is cost effective. Furthermore, it serves the VA's mandatory constituency, the Category A patient. Despite these facts, resource concerns at White River Junction mean that VICC may not survive beyond this fiscal year. At the very least, VICC will have demonstrated that a VA-State collaboration can produce a model for rural mental health care. At the most it may provide to be an enduring system of care that will continue to serve the veterans of Vermont.

Thank you for your interest and concern. I will be happy to provide any additional information that you wish.

Sincerely,

Matthew J. Friedman, MD PhD

MATTHEW J. FRIEDMAN, M.D., Ph.D.
Chief, Psychiatry Service

Integration of VA and CMHC Care: Utilization and Long-Term Outcome

Matthew J. Friedman, M.D., Ph.D.
Alan N. West, Ph.D.
Austen Clark, D.Phil.

An innovative treatment program was established through which VA outpatient mental health care was decentralized via integration with the CMHC system in northern Vermont. A long-term follow-up study evaluated the success of Veterans' Integrated Community Care (VICC) in meeting its goal of enhanced access to care and better treatment outcomes. Three groups were compared: veterans who were transferred from VA hospital care to VICC care, veterans who were treated at the VA hospital only, and veterans who were newly reached through the VICC program. Follow-ups were conducted 18 months after intake and at least two years thereafter. Results indicate that all groups were improved symptomatically at the first follow-up, but only VICC patients maintained this improvement subsequently. By the last follow-up, VICC patients had reduced their utilization of VA psychiatric care, whereas veterans who had received only hospital-based care had not. VICC treatment represents a viable alternative to centralized VA mental health care.

Decentralization of mental health care began with the Community Mental Health Centers Act of 1963 (P.L. 88–164, Title 2). This legislation aimed to increase public access to treatment; traditionally public psychiatric care was provided on a centralized, regional basis. With the CMHC movement, mental health services were dispersed into multiple catchment areas, thereby enhancing the availability of care for the underserved.

Predictably, greater access to care led to dramatically increased utilization of mental health services (1–4). Use of catchment areas also induced the development of innovative treatment approaches to meet the increased demand for services. Brief psychiatric hospitalizations (5–7) became more commonplace as aftercare and alternative programs emphasizing family involvement, social and vocational skills training, community-based residential care, and day hospital treatment were introduced (8–18). Alternative outpatient treatment programs have substantially reduced the utilization of inpatient psychiatric services (16–18).

The shift from hospital to community-based treatment during the past 30 years was spearheaded by politicians rather than by the professional community. Planning for the community mental health movement was based on very limited scientific data (19,20). Moreover, the evidence available today is still inefficient for evaluating the efficacy of community-based care. According to Langsley (20), most reports have provided simple "head counts" of state hospital alumni reregistered in community programs rather than evaluations of clinical outcomes. Mollica (21) concluded that "outcome studies on public programs do not exist."

Hence much remains to be learned about the efficacy of community based care relative to traditional, centralized services. We were fortunate to have a unique opportunity to study this issue within the context of the Veterans Administration's system of care. Currently the VA continues to deliver its mental health services on a centralized basis. The VA at large has neither adopted the community-based service delivery model nor made structural changes such as decentralizing outpatient services. Although VA mental health care is provided free of charge to veterans, its centralized delivery mode often precludes ready accessibility. Within this context, we developed and evaluated the efficacy of an experimental program of decentralized mental health care for veterans.

The treatment program was implemented and administered by the Veterans Administration Hospital in White River Junction, Vermont. The catchment area served by this hospital comprises all of

Dr. Friedman is chief of psychiatry and Dr. West is acting director of outpatient psychiatry at the Veterans Administration Medical Center in White River Junction, Vermont. Dr. Friedman is also associate professor in the department of psychiatry and associate professor in the department of pharmacology at Dartmouth Medical School in Hanover, New Hampshire; Dr. West is research assistant professor in the department of psychiatry there. Dr. Clark is associate professor in the department of philosophy at the University of Tulsa. Dr. Friedman's address is VA Medical Center, White River Junction, Vermont 05001. This research was supported by a health services research and development grant from the Veterans Administration.

Vermont and five counties of western and northern New Hampshire. The area is primarily rural (85 percent of the people live in towns of fewer than 10,000), the population is predominantly Caucasian, and poverty is common. Considerable social and cultural encapsulation exists; for example, adolescent runaways rarely travel more than 50 miles away.

Because of mountainous terrain, harsh winter conditions, and lack of a convenient east-west highway system, it is often difficult for veterans to travel the long distances to and from the VA hospital. Moreover, the hospital's centralized care generally does not provide for family treatment, does not permit intensive aftercare and follow-up, and is often costly to veterans in terms of lost work time.

Between October 1, 1979, and December 31, 1981, the hospital administered its innovative program of decentralized mental health care delivery. The program aimed to enhance access to VA mental health care through the integration of services with the Vermont community mental health center system. VA psychiatric social workers were assigned to work at selected community mental health centers with the mandate to provide psychotherapy and to expedite and coordinate the treatment needs of veterans residing in the CMHC catchment area. This treatment program was known as VICC—Veterans' Integrated Community Care.

The VICC treatment program was evaluated by assessing utilization and long-term treatment outcomes. Participants in the program were compared with veterans who continued to receive outpatient treatment at the VA hospital. A broad range of outcome measures were considered, including psychiatric symptomatology, therapeutic goal attainment, employment status, substance abuse, and level of involvement with family or friends. This report describes the program's efficacy in terms of relative changes from baseline functional levels as well as the relative permanence of these changes. In addition, it addresses the program's impact on the utilization of health care services.

It should be emphasized that the VA outpatient population differs from the populations usually studied in the deinstitutionalization-decentralization literature. On the one hand, although the VA treats many chronic, permanently disabled psychiatric patients, its outpatient psychiatric population is generally healthier and more diverse than the chronic deinstitutionalized state hospital alumni who have served as subjects for many studies. On the other hand, the chronicity and morbidity of the VA population are far greater than for the population at large, which has been investigated in community or catchment area studies.

In summary, several hypotheses were inherent in the program. We hypothesized that the VA system could be meshed with the community mental health system to permit VA mental health professionals to operate full-time at CMHC sites. We assumed that by enhancing access to VA-sponsored care in this manner, we could alter veterans' utilization patterns and reduce the long-term consumption of hospital-based care. And we predicted that the greater accessibility of decentralized and integrated mental health services would improve the veterans' outcome.

Method

The program

VICC services were established in two community mental health center catchment areas in northern Vermont. Two other catchment areas (one in Vermont, one in New Hampshire) served as control areas. Control areas were selected to match the experimental areas demographically and geographically in terms of distance from the VA hospital. Throughout the study, veterans who resided in the control areas received VA mental health care at the hospital only. Veterans from the experimental areas could opt to be treated at the VA hospital, receive VICC services at the local community mental health center, or do both.

Two VA psychiatric social workers, known as VICC clinicians, were placed in each of the community mental health centers in the experimental areas. They functioned as regular members of the treatment staff except that they treated only veterans of military service. The clinicians participated in clinical supervision, case conferences, and peer review fun[illegible] as did non-VA members of the CMHC staff. They were recruited by VA hospital and CMHC staff jointly and were expected to meet both VA and CMHC performance standards.

Services provided by VICC clinicians included psychotherapy, aftercare, liaison to the VA hospital, and sharing of responsibilities and on-call duties with other CMHC staff. VICC clinicians were the primary therapists for veterans, and they provided support to veterans' families by referring them to other services available through the community mental health center. After exploring community alternatives exhaustively, VICC clinicians screened veterans for hospitalization at the VA hospital. They facilitated continuity of care with the hospital by providing inpatient staff with CMHC treatment records, information about family, and other data relevant to treatment planning, and they collaborated in the development of long-term treatment goals.

VICC clinicians also provided aftercare services, including therapy and referrals to community support services, to veterans who were discharged from VA psychiatric hospitalization. The clinicians provided counsel on VA benefits and referred their clientele to other programs at the community mental health center (such as transitional care, day treatment, and alcohol and substance abuse treatment) as indicated.

The community mental health centers provided office space, secretarial and administrative support, clinical supervision, and clinical support for the VICC clinicians. In exchange, the clinicians participated in the centers' emergency and on-call rotations.

Program evaluation

Three subject groups were identified for comparison. "Transfers" included veterans from experimental areas who had been receiving psychiatric care at the VA hospital and chose to transfer to the VICC clinicians. "Community controls" included veterans from experimental areas who had not been in outpatient psychotherapy during the preceding year and whose port of entry to the VICC program was the community mental health center rather than the VA hospital. "VA controls" were veterans from control areas who received VA mental health care at the VA hospital only. There were a total of 94 transfers, 116 community controls, and 116 VA controls.

Each subject underwent a series of structured interviews administered by a trained, bachelor's-level interviewer. Interviews were conducted when the subject entered the study, 18 months after entry, and approximately two years after the 18-month follow-up. The initial interview assessed numerous background variables, including demographics such as age, education, annual income, employment status, marital status, and household composition, and past utilization of a variety of VA and non-VA mental health services. Recent psychosocial stressors were measured by Holmes and Rahe's Social Readjustment Rating Scale (SRRS) (22), and baseline functional levels on several outcome measures were assessed, including the Symptom Checklist 90 (SCL-90) (23), a self-report measure of psychiatric symptomatology; a questionnaire assessing frequency of alcohol and drug abuse during the previous month; and two indexes of social participation—the Family Involvement and Involvement With Friends Scales (standardizations are reported by Clark and Friedman [24]).

The 18-month follow-up assessment involved all of the outcome measures listed above as well as the Goal Attainment Scale (25), which reflects a client's rating of progress toward therapeutic goals established at intake. Utilization of mental health services during the 18-month period was assessed via searches of VA and CMHC clinical records.

Table 1
Group characteristics of transfers, VA controls, and community controls at intake

Variable	Transfers (N=94)		VA controls (N=116)		Community controls (N=116)	
	Mean	SD	Mean	SD	Mean	SD
Age	33.0	12.7	49.0*	12.6	40.1	12.7
Education (years)	11.7	2.6	11.5	2.9	12.2	2.5
Annual income (thousands of dollars)	10.2	6.1	10.9	9.1	10.3	6.9
Weeks unemployed in previous year	27.5	22.5	35.5*	21.5	22.1	21.4
Dependents	1.0	1.5	2.7	1.6	3.2	1.9
Persons in household	2.8	1.6	2.7	1.6	3.0	1.9
SRRS score	100.7	74.8	82.4**	72.6	110.4	72.8

*VA controls differed significantly from transfers and community controls at p<.001.
**VA controls differed significantly from community controls at p<.05

Of the 94 transfers in the program, 91 completed the 18-month outcome interview. Fifty of the 116 community controls completed the interview, and 93 of the 116 VA controls did so. Comparisons of baseline outcome data for subjects who remained in the study and those who dropped out before the 18-month interview revealed no significant differences. Since our outcome findings were not distorted by the attrition of subjects, we confined all subsequent analyses to subjects who were followed for the full 18 months of the program.

The final interview reassessed outcomes and utilization of mental health care an average (±SD) of 27.8 months±4.5 after the 18-month interview (the range was 17.5 to 35.8 months). Subjects were asked to estimate their number of visits to local community mental health centers, including former VICC treatment sites, and any other non-VA facilities during the interval between the 18-month and the final interview. The final interview was completed by 49 transfers, 43 community controls, and 66 VA controls. Again, within each group initial values on outcome measures were not significantly different for those who were lost to follow-up between the 18-month assessment and this final assessment and those who were followed to the final interview.

Results

The groups were compared on each variable assessed at the initial interview. Table 1 shows group means and standard deviations for selected demographic variables and the SRRS. In general, the groups were comparable demographically. However, compared with veterans who received community care (the transfers and the community controls), veterans who received care at the hospital (the VA controls) were older and had worked less during the previous year. The VA controls' scores on the SRRS were significantly lower than those of the community controls, indicating that VA controls had experienced fewer stressful events.

Community controls, on the other hand, were more likely to be working at intake ($\chi^2=11.34$, $df=2$, $p<.01$). Close to 54 percent of the community controls were working at intake, compared with 37 percent of the transfers and 27 percent of the VA controls.

The groups did not differ significantly at intake on the SCL-90, the Family Involvement or Involvement With Friends Scales, average monthly consumption of alcohol or frequency of drinking, and frequency of drug abuse. These measures indicated that the subjects

were impaired symptomatically and interpersonally and tended to abuse alcohol but not other drugs.

Service utilization

Figure 1 shows each group's average monthly utilization (and the standard error) of VA sponsored outpatient mental health care both at the VA and in the community during three time intervals: the 18 months preceding the community care program, the 18 months of the program, and the two years afterward. Groups differed significantly in their consumption of VA hospital-based care before the program ($F=24.27$, $df=2,322$, $p<.001$). Scheffé's test revealed that community controls attended fewer sessions at the VA hospital than did the other groups. During the program, community controls attended fewer sessions at the VA hospital than did the transfers, who in turn attended fewer than did the VA hospital controls ($F=25.25$, $df=2,274$, $p<.001$). As the figure shows, utilization of community care was much higher than utilization of VA hospital-based care. During the post-VICC period, groups did not differ significantly in their utilization of VA hospital outpatient psychiatric care.

To determine whether access to the community-based treatment program reduced subsequent utilization of centralized VA hospital care, we compared each group's monthly use of hospital care during the 18 months preceding the VICC program with its monthly use of hospital care after the program ended. Transfers showed a significant reduction in their use of VA hospital care after the program ($t=3.31$, $df=40$, $p<.01$), whereas the control groups showed no significant change. Access to VICC care reduced the transfers' subsequent utilization of VA hospital psychiatric care, whereas VA controls' utilization of VA care remained fairly constant throughout the study. For community controls, access to community care did not increase consumption of VA hospital psychiatric care later.

The VICC program arose from an assumption that rural veterans need and want mental health care closer to their own communities. To test this assumption, we examined the number of sessions the three groups attended at non-VA hospital and non-VICC mental health care sites during the 18 months of the community care program. As expected, VA controls (who were not eligible for VICC services) used more of these alternative services than did the transfers or the community controls ($F=8.75$, $df=2,321$, $p<.001$).

VA controls who used alternative services during the VICC program, compared with VA controls who did not, attended fewer outpatient psychiatric sessions at the VA hospital during the 18 months preceding the program ($t=3.58$, $df=111$, $p<.001$). They also attended fewer outpatient sessions at the VA hospital during the program ($t=2.02$, $df=112$, $p<.05$). However, they reported more symptomatology on the SCL-90 at the initial interview than did VA controls who did not use alternative services ($t=2.34$, $df=111$, $p<.05$). In other words, VA controls who were most symptomatically distressed at intake tended to rely on community-based rather than VA hospital care.

The differences found among the groups in alternative services used during the VICC program were not found at the final assessment. The three groups did not differ significantly in their number of visits to local community mental health centers or to other non-VA mental health services during the approximately two years after the program ended. This may reflect the fact that all groups reported lower utilization of alternative mental health resources during this period.

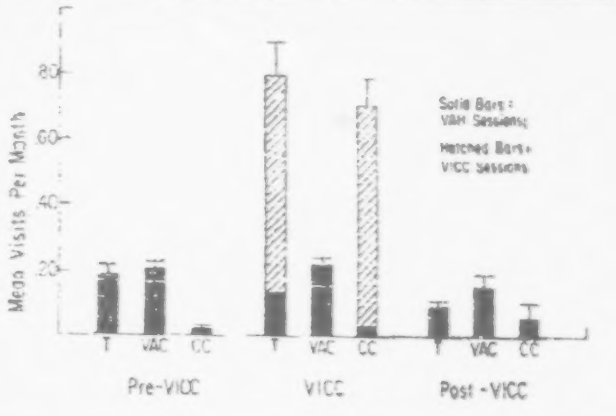
Outcome measures

The SCL-90. The groups' scores on the SCL-90 did not differ significantly at intake. Figure 2 shows the mean changes (plus standard errors) in the scores from the initial interview to the 18-month follow-up and from the initial interview to the post-VICC follow-up. Changes in symptomatology were assessed via repeated measures analysis of variance, with treatment group as a between-subjects factor and interview as a within-subjects factor.

An analysis of changes from in-

Figure 1

Mean monthly outpatient visits to VA hospital and Veterans' Integrated Community Care sites by transfers (T), VA controls (VAC), and community controls (CC) before, during, and after the VICC program



T-shaped line indicates standard error.

take to 18-month follow-up revealed a significant main effect for interview, which indicated general reduction in symptomatology across groups ($F=10.53$, $df=1,187$, $p<.001$). There were no significant differences between groups. Analysis of baseline scores and post-VICC follow-up scores also yielded a significant main effect for interview ($F=8.79$, $df=1,150$, $p<.01$) as well as a significant interaction of group with interview ($F=4.51$, $df=2,150$, $p<.05$). As Figure 2 shows, those who participated in the community care program (the transfers and community controls) maintained longer term improvement in symptomatology, whereas those who did not (the VA controls) returned to baseline levels.

Other measures. The groups did not differ significantly at intake on the Family Involvement or Involvement With Friends Scales, average monthly consumption of alcohol or frequency of drinking, or frequency of drug abuse. In addition, they showed few significant differences on such measures at either the 18-month or the post-VICC follow-up. The groups did not differ with respect to their achievement of therapeutic goals (the GAS) or to changes in employment rate, family involvement, frequency of illicit drug use, or frequency of alcohol use. Average monthly consumption of alcohol did decrease across groups from 26 ounces at intake to 18 ounces at the final follow-up ($F=3.91$, $df=1,199$, $p<.05$).

The groups did show some differences, however, in their involvement with friends. Although this measure was unchanged at the 18-month follow-up, the main effect was significant at the posttreatment interview ($F=4.35$, $df=1,188$, $p<.05$). An interaction of interview with group indicated that transfers' involvement with friends improved substantially and community controls' involvement improved somewhat, whereas VA controls' involvement declined slightly ($F=4.00$, $df=2,188$, $p<.05$).

In summary, transfers showed significant improvement in SCL-90 symptomatology at the 18-month interview and even greater improvement two years later at the post-VICC follow-up. They also reported greater involvement with friends at the final follow-up. Community controls also improved on the SCL-90 at 18 months and subsequently. VA controls were improved symptomatically at the 18-month interview but returned to their baseline SCL-90 levels at post-VICC follow-up.

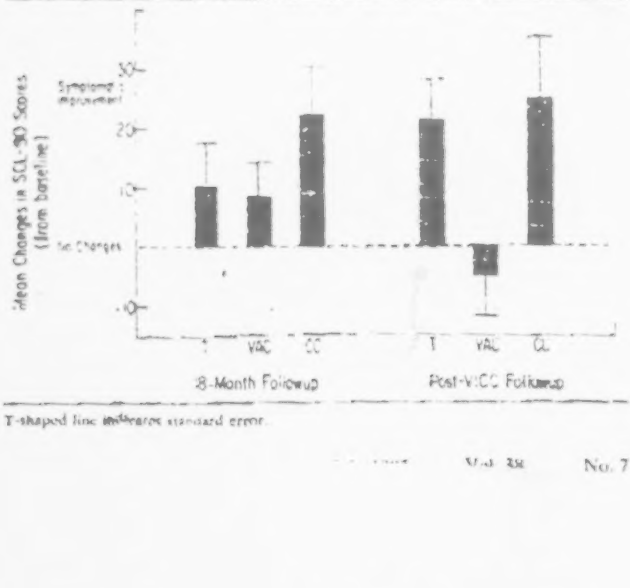
Discussion

Through the Veterans Integrated Community Care program, VA mental health care was provided to rural veterans in or near their own communities. Among psychiatric outpatients who were transferred from VA hospital-based care to VICC care, the impact of this innovative treatment approach on both utilization patterns and outcomes was substantial. Transfers who had been customers at a VA hospital outpatient psychiatric clinic were weaned from that delivery mode and reoriented toward community-based services. VA controls, who were similar to the transfers in their demographic and psychiatric backgrounds, did not show a comparable reduction in utilization of VA hospital psychiatric care. More important, transfers maintained a significant improvement in psychiatric symptomatology for at least two years following VICC treatment, while VA controls relapsed to intake functional levels. Following the VICC program, transfers functioned better and used less VA hospital-based care than the VA controls.

The community controls also showed sustained symptomatic improvement after the community care program ended. They had utilized VICC treatment as extensively as the transfers, but they were not drawn into the VA system to become long-term consumers subsequently. By the end of the study, community controls utilized no more VA hospital psychiatric care than they had before the VICC program began.

Hence the VICC treatment program served dual functions. By improving access to VA therapists, it brought free mental health treatment to a new group of veterans. By providing a transition from the VA hospital to the community, it gradually weaned long-term consumers from VA hospital-based care. In both cases, it demonstrated its long-term effectiveness as a treatment modality. Though all

Figure 2
Mean changes in SCL-90 scores for transfers (T), VA controls (VAC), and community controls (CC) from baseline to 18-month follow-up and from baseline to final follow-up



T-shaped line indicates standard error

cations, Project ACCESS also educates the public about mental health issues through presentations to self-help groups, law enforcement agencies, mental health professionals, private and public agencies, legislators, educational institutions, and neighborhood organizations. Project ACCESS staff have given presentations at local and national conferences, participated in several radio talk shows, and developed a public service announcement.

The collaborative development of Project ACCESS publications has ensured their widespread relevance and has created greater cooperation among Philadelphia's mental health service agencies. Project ACCESS has not only helped consumers understand and use Philadelphia's mental health service system; its work has also improved the system.

For more information contact Phyllis Ledbetter, Director, Mental Health Association of Southeastern Pennsylvania, 311 South Juniper Street, Philadelphia, Pennsylvania 19107, telephone, 215-735-2465.

Accessible Psychiatric Outpatient Treatment for Veterans—Veterans Integrated Community Care Program, Veterans Administration Medical and Regional Office Center, White River Junction, Vermont

Veterans living in remote parts of Vermont and northern New Hampshire no longer must battle harsh New England winters, an inadequate cross-state road system, and mountainous terrain to obtain psychiatric outpatient services at the Veterans Administration Medical Center in White River Junction. Through an innovative arrangement between the VA and six regional community mental health centers, they can receive the same outpatient services they would have received from the hospital at their local community mental health center.

The VA Hospital in White River Junction serves a large catchment area comprising all of Vermont and five counties in western and northern New Hampshire. A large majority of the area's residents, 85 percent, live in towns of fewer than 10,000, and many are poor. Affiliated with Dartmouth Medical School, the hospital has 224 beds and offers acute medical, surgical, and psychiatric inpatient treatment. It also operates a 16-bed alcoholism rehabilitation program, an ambulatory surgical program, and a 30-bed nursing home unit. The hospital is one of the state's primary providers of mental health services and at its current pace will have approximately 7,000 psychiatric outpatient visits this year.

Under the program, called Veterans Integrated Community Care, or VICC, the VA takes full responsibility for providing outpatient services for veterans in the CMHCs' catchment area in return for the use of the centers' facilities and staff support. Both the VA and the centers view the program as a fair exchange, according to Matthew Friedman, M.D., Ph.D., chief of the hospital's psychiatry service and the program's originator, and no money changes hands between them.

Master's-level therapists, called VICC clinicians, provide the bulk of outpatient treatment for veterans at the community mental health centers. All of the participating centers except the one in Burlington are assigned one VICC clinician. Two VICC clinicians work in Burlington, where a third of the patients in the VA's catchment area reside. VA psychiatrists work part time in the centers serving Rutland County, Burlington, and the Northeast Kingdom region, all in Vermont.

The VICC clinicians play an important role in ensuring continuity of care within the VA system. They screen acutely ill veterans and explore all alternatives to inpatient care. If hospitalization of the patient becomes necessary, they provide the VA's inpatient staff with the patient's treatment records and important clinical information, such as details about the patient's family problems. The VICC clinicians also work with the inpatient staff to develop comprehensive treatment goals that can be pursued after the patient's discharge. The clinicians resume therapy with the patients after their discharge and make sure they are referred to the appropriate community support services.

Although they are supervised by the hospital-based project director, the VICC clinicians are considered members of the CMHC staff. They participate in the center's on-call-duty rotation, provide VA benefits counseling to the center's patients, and make regular referrals to other CMHC programs, such as those providing transitional care, day treatment, and alcohol and substance abuse treatment. The centers and the VA share responsibility for recruiting the VICC clinicians.

Project director Lorraine E. Peirce, R.N., M.A., plays a key role in ensuring that the program runs smoothly, said Dr. Friedman. Ms. Peirce meets with each VICC clinician at least three times a month, twice at a CMHC and once at the hospital in White River Junction. During her visits to the centers, she provides the VICC clinicians with clinical and administrative supervision and reviews the clinicians' performance with their supervisors at the centers. She facilitates good communication between the VICC clinicians and the inpatient staff.

The VICC program was proved effective in pilot testing conducted between 1978 and 1981 at two

Vermont CMHCs. A follow-up study comparing outcomes of veterans served in the VICC with those served at the VA hospital indicated that while both groups improved, only the VICC-treated veterans maintained their improvement over the nearly four-year follow-up period. Treatment through the VICC program was also substantially less expensive, costing $14 to $20 a visit compared with $32 to $38 a visit for hospital-based outpatient care. These results, as well as increased interest by the VA in developing alternative and innovative treatment strategies, contributed to the renewal of the program in 1987, said Dr. Friedman, who led the team that conducted the follow-up research.

The program has helped the VA overcome its long isolation from the rest of Vermont's mental health community, Dr. Friedman said. That's good for the VA, he believes, and especially good for the many veterans who are now minutes, not hours, away from a dependable source of outpatient mental health treatment.

For more information contact Matthew J. Friedman, M.D., Ph.D., Chief, Psychiatry Service, Veterans Administration Hospital, White River Junction, Vermont 05001; telephone, 802-295-9363, ext. 591.

Assertive At-Home Case Management for Impaired Elderly Persons—Elderly Services Program, Spokane (Wash.) Community Mental Health Center

Many highly dysfunctional elderly residents of Spokane, Washington, continue to lead productive lives in the community thanks to the comprehensive care provided by the Elderly Services Program of the Spokane Community Mental Health Center. Ray Raschko, M.S.W., is director of the program, which has been in operation since 1978. Mary Higgins is executive director of the community mental health center.

The program has two main components—at-home services providing evaluation, treatment planning, and aggressive case management for very impaired and socially isolated elderly individuals and 24-hour telephone information and referral for higher-functioning elderly persons and those with more adequate social support systems. In addition, it conducts aggressive outreach through an extensive network of community "gatekeepers."

Each individual enrolled in the at-home case management program, coordinated by Francie Coleman, is assigned to a multidisciplinary team. Five of the teams are staffed by three case managers and a trained geriatric mental health specialist, usually a nurse, who serves as team leader. A sixth team is staffed by three social work students from the School of Social Work at Eastern Washington University and is led by their practicum supervisor, also a social worker.

Treatment plans are drawn up by a case manager and the team leader, who are responsible for ensuring that the elderly patients receive any and all services they need to maintain their independence and avoid premature or unnecessary institutionalization. Some of the services most commonly required by the elderly patients are nursing care, legal assistance, meal delivery, help in obtaining Medicaid or food stamps, and assistance with housekeeping, food preparation, and home repairs. The services are provided through contracts with 14 local agencies, most of which are funded by the Eastern Washington Area Agency on Aging, which provides 60 percent of the program's funds. (The Washington State Mental Health grant-in-aid program and the National Institute on Drug Abuse provide the rest.)

A staff psychiatrist, who works in the program 35 hours a week, and family medicine residents from the University of Washington provide the elderly participants regular in-home evaluation and treatment. The case managers continue to make regular visits to the elderly participants for as long as they remain in the program. Treatment plans are reviewed every 30 to 90 days by the case manager and the team leader in charge of the case.

Staff of agencies that provide contractual services receive 20 hours of training from the elderly services program about dementia, depression, mental status, and medications. They are asked to report to the program any decline in the elderly participants' functioning and are expected to attend weekly case conferences. A special group of 25 higher-paid agency staff receive additional training in working with behaviorally disturbed elderly persons and are assigned to the homes of those who are at the greatest risk of institutionalization.

One of the most innovative aspects of the program is its reliance on a network of community residents, or "gatekeepers," to identify elderly individuals who require mental health and medical interventions. Gatekeepers are individuals who come into regular contact with the elderly, usually through their work. They include gas and electric company repair workers, postmen, managers of apartments and mobile home communities, pharmacists, fuel oil distributors, grocery store employees, water meter readers, and police and fire fighters. Referrals by gatekeepers account for four of every ten admissions to the case management program, according to Mr. Raschko.

In 1987 the Elderly Services Program provided at-home services to 636 elderly individuals with serious economic and health problems. Sixty-two percent of the par-

STATEMENT OF

HON. EDWARD J. DERWINSKI

SECRETARY OF VETERANS AFFAIRS

NOVEMBER 15, 1989

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MR. CHAIRMAN, I WANT TO THANK YOU FOR INVITING US HERE TODAY TO DISCUSS OUR PROGRAMS IN RURAL HEALTH CARE FOR VETERANS. WITH ME ARE MY GENERAL COUNSEL, MR. RAOUL CARROLL, AND DR. DANIEL WINSHIP AND MS. MARJORIE QUANDT OF THE VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION.

I AM PLEASED TO BE HERE TO HELP WITH THIS DISCUSSION. THE RURAL PROGRAMS ARE A VERY IMPORTANT, CONTINUING ACTIVITY OF THE VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION, AND THEY ARE GROWING IN PROMINENCE. THIS HAS BEEN TRUE FOR A NUMBER OF YEARS.

MR. CHAIRMAN, A SCHEDULE CONFLICT PREVENTS ME FROM REMAINING FOR THE ENTIRE HEARING.

MR. CHAIRMAN, AS THE FORMER GOVERNOR, AND FOR THE IMMEDIATE PAST YEARS, A UNITED STATES SENATOR FROM THE RURAL STATE OF WEST VIRGINIA, YOU'RE KEENLY AWARE OF CONSTITUENT INTEREST IN RURAL HEALTH CARE ACTIVITIES, INCLUDING THOSE OF THE DEPARTMENT I HAVE THE HONOR TO LEAD.

MR. CHAIRMAN, WE IN VA DO ADDRESS THIS ISSUE WITH SERIOUSNESS. COMMON SENSE AND MANY CAREFUL STUDIES HAVE SHOWN THERE IS A PAUCITY OF HEALTH SERVICES IN RURAL AREAS; THE POPULATIONS ARE POORER THAN THEIR URBAN COUNTERPARTS; AND OLDER IN GENERAL, WITH BOTH CHRONIC AND ACUTE ILLNESS.

MUCH HAS BEEN DONE IN RECENT YEARS TO TRY TO IMPROVE HEALTH SERVICES IN RURAL AND REMOTE COMMUNITIES. MORE CAN BE DONE, BUT IN THE FEDERAL SECTOR, THIS COMMITTEE IS AWARE THAT VA FUNDS ARE SCARCE AND HEALTH CARE IS GROWING MORE AND MORE EXPENSIVE. AS OUR FORMAL TESTIMONY STATES, VA IS INVESTING NEARLY TWO HUNDRED MILLION DOLLARS EACH YEAR IN OUTPATIENT ACTIVITIES OUTSIDE OUR BASIC MEDICAL CENTERS. WE NEED TO BE VERY CAREFUL IN CONTINUING TO SPEND HIGHER AND HIGHER AMOUNTS--THE DEMAND IS ALMOST UNLIMITED, AND THE RESOURCES ARE HARD TO JUSTIFY FROM CONGRESS, AMONG THE COMPETING INTERESTS FOR TAXPAYER DOLLARS.

A NUMBER OF ALTERNATIVE ARRANGEMENTS ARE POSSIBLE TO MEET PRESSING NEEDS IN RURAL AREAS, AND VA WILL BE PURSUING THEM THROUGH OUR PLANNING SYSTEMS, AND THROUGH THE BUDGET PROCESS.

I DO BELIEVE, MOREOVER, THAT WE SHOULD FOCUS MORE IN THE FUTURE ON WHAT IS PRACTICAL AND SAFE, RATHER THAN TEND TO DO WHAT WE HAVE OFTEN DONE IN THE PAST, WHICH IS TO BUILD OR OTHERWISE ESTABLISH PERMANENT OUTPATIENT CLINICS. SOME OF THIS PROBLEM, I BELIEVE, CAN BE SOLVED WITH GREATER ATTENTION TO THE ISSUE OF TRANSPORTATION SYSTEMS, WHICH COULD MEAN THE SOLUTION LIES OUTSIDE WHAT IS CONSIDERED "NORMAL VA BUSINESS." IF EFFECTIVE, EFFICIENT TRANSPORTATION IS AVAILABLE FOR RURAL VETERANS, REMOTENESS BECOMES LESS THREATENING TO THEM AS A HEALTH CARE MATTER. EMERGENCIES MUST BE HANDLED BY WHATEVER LEVEL OF COMMUNITY MEDICAL CARE THERE IS, BUT WE CAN PARTICIPATE IN THAT PROCESS WITH MORE CREATIVE APPROACHES TO SHARING WITH COMMUNITY PROVIDERS. IN THE MIX WE CAN IMPROVE HEALTH CARE FOR VETERANS, AND PROMOTE BETTER CARE FOR THE LARGER RURAL POPULATIONS AS WELL.

MR. CHAIRMAN, THERE ARE THOSE WITH ME TODAY MUCH MORE EXPERT THAN I ON THIS COMPLEX TOPIC, AND I WANT TO DEFER TO THEM YOUR QUESTIONS. I DO APPRECIATE YOUR ALLOWING ME TO PRESENT THIS TESTIMONY.

THANK YOU VERY MUCH, MR. CHAIRMAN.

STATEMENT OF

DANIEL H. WINSHIP, M.D.

ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR

VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION

DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE

SENATE VETERANS' AFFAIRS COMMITTEE

NOVEMBER 15, 1989

Mr. Chairman and Members of the Committee:

We are pleased to be here this morning to testify in connection with the Committee's continuing interest in health care for veterans living in geographically remote and rural areas of our country. Accompanying me today are Mr. Raoul Carroll, our General Counsel, and Miss Marjorie Quandt of our Veterans Health Services and Research Administration (VHS&RA).

Congressional and VA concern for health care to veterans living in geographically remote and rural areas has resulted in a series of initiatives dating back several years. I would like to briefly summarize some of the most recent of these initiatives, and the associated Departmental policy for meeting health care needs of veterans living in geographically remote and rural areas.

The 1985 Veterans' Health Care Act (Section 202 of P.L. 98-528) required two reports on health care for veterans in remote areas.

The first report, "Study of Health Care Services to Veterans Living in Geographically Remote Areas," forwarded to Congress in February, 1986, listed two significant conclusions: 1) only three percent of 28 million veterans at that time resided more than 100 miles from a VA facility; and 2) a variety of VA health care delivery mechanisms could be used as means for reaching these veterans. These mechanisms included VA medical centers themselves, VA-DOD shared services, VA contracting for services, VA fee-basis care by community providers, and a variety of VA outreach programs.

Congress recommended that VA continue to develop and use innovative approaches for health care delivery in remote areas, with the recognition that additional outreach efforts would be a matter of priority setting and demonstrated cost effectiveness. Congress recognized also that a shifting of resources from other VA programs might be necessary to extend VA services to rural and remote locations.

The second report, required by P.L. 98-528, "Health Care for Veterans in Remote Areas: Second Report," issued by the Administrator in August, 1986, concluded that VA's wide variety of programs already available to a large majority of veterans in remote areas adequately addressed issues of rurality and remoteness as barriers to health care. In this report, VA recommended that Congress not authorize any new, targeted rural health care demonstrations or experiments.

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On October 16, 1986, the text of the Senate Appropriations Committee Report which accompanied P.L. 99-500 required a report on ways to improve access to health care for veterans living at least 100 miles or three hours travel time from a VA health care facility. In addition, VA was directed to conduct two pilot demonstrations during FY 1987 of the most promising alternative(s) for improving access to care using funds available within the VA's Medical Care appropriation for that year.

The report, "Alternatives for Veterans' Health Care in Remote Areas," was completed and forwarded to Congress in January, 1987. Two community-based clinics, one in Farmington, New Mexico, and the other in Redding, California, were chosen as demonstration sites. The clinics have been activated and an evaluation is proceeding on schedule. The evaluation is being conducted by our Health Services Research and Development Center in Palo Alto, CA. A final evaluation report will be completed and provided to Congress next year.

In April 1987, your Committee conducted an unprecedented field hearing in Honolulu, Hawaii to consider the extent of underservice to eligible Hawaii Veterans, particularly of those residing on Hawaii's remote and rural neighbor islands. As a result of the hearing, we established a special VA health care task force, which Miss Quandt chaired, to address these issues. The task force recommended a series of new VA services, including community based

clinics on each of the neighbor islands; new and expanded programs and resource levels at our outpatient clinic in Honolulu; and, crucially, an independent VA medical center in Hawaii. Many of these improvements are now in place, and our work progresses in planning for the new VA medical center.

In the FY 1988 Appropriations Conference Committee Report, our Albuquerque VAMC was directed to establish six outpatient clinics, using the mobile team concept, in rural New Mexico. One community-based clinic was implemented in February 1989, in Artesia, NM, with others to be considered within available funds.

Public Law 100-322, Section 113, authorized VA to complete a two year pilot program, with reports, to evaluate use of innovative mobile clinics in four geographical areas of the U.S. However, this initiative was premised on specific appropriations, and Congress chose not to appropriate them prior to FY 1990. We understand $3 million in Medical Care funding is provided in the FY 1990 Medical Care appropriation. Thus, we will commence work in FY 1990 to implement this authority. Nevertheless, as we have indicated before, we are concerned about the cost effectiveness of mobile clinics, which studies have shown to be highly problematic and difficult to sustain. I assure the Committee that in this day of resource constraint, we will carefully evaluate this program.

PLANNING AND OPERATIONAL INITIATIVES

The 1985 VA study of health care services to veterans living in geographically remote areas identified 84 counties as so remote from VA medical centers that the study suggested alternative care arrangements be considered for veterans living in these areas. Several of the locations have been considered through the MEDIPP planning process since that time. As a result, several proposals to establish clinics were made, and some have been activated.

By 1985, concerns about the proliferation of non-medical center-based ambulatory care activity led the then-Chief Medical Director, Dr. John Ditzler, to not only authorize establishment of criteria and standards for new outpatient services remote from VA medical centers, but to request also a specific review be made of information sources relative to these outpatient activities. A baseline survey of all outpatient activities was completed in July, 1988, to fulfill this requirement.

This "snap shot" survey of our clinics disclosed the following resource indicators. At that time staffing included 559 physicians, 684 nursing staff, 298 social workers, 189 pharmacists and 1,097 medical administration staff. Operating costs for FY 1987 were reported for 184 (83% of the outpatient programs). The 39 (17%) programs that did not report cost information included 3 satellite outpatient clinics (SOC), 8 community-based clinics (CBC), and 28 outreach program/clinics (ORC). Some of these

programs were not reported because they had not been in operation for a full year in FY 1987; others indicated that the cost could not be separated out from other VAMC outpatient costs. An estimate of the cost of all outpatient activities reported as being held away from VA medical centers was determined to be $193,042,589 for FY 1987.

The average annual operations cost for each type of outpatient activity was:

Satellite Clinic	$4,117,238
Community-based Clinic	848,421
Outreach Program	35,451

The average costs per visit for SOCs, CBCs and ORCs were as follows:

Satellite Clinic	$80.30
Community-based Clinic	81.60
Outreach Program	24.30

Criteria and standards for establishing Satellite and Community-based clinics were developed and published in November 1987 to define the various types of clinics and govern planning for new clinics in areas of underservice.

Based on our criteria and standards, a Satellite Outpatient Clinic (SOC) is a full-time, freestanding, ambulatory care facility that is physically separated but administratively attached to a VA medical center. It is usually located in a highly populated area so that a large concentration of veterans may obtain primary care and some specialty outpatient services. A SOC has a workload range of 25,000 to 150,000 outpatient visits annually and staffing of at least 38 FTEE.

A Community-Based Clinic (CBC), also full time and freestanding, is usually located in a less populated area than is a satellite clinic. A CBC provides primary care and post-hospital follow-up; occasionally one or more specialty services are provided. It produces a workload of 3,000 to 24,999 outpatient visits annually. Staffing ranges from 2.5 to 38 FTEE.

An Outreach Program/Clinic (ORC) is either a part-time activity in which one or more VA medical center staff travel to provide services to veterans in their own communities, or a small outpost comprised of one or two VA staff. Types of ORC services vary depending upon local circumstances and veteran needs. Scheduling may be flexible, with or without a fixed base of operation. Such a program is often innovative in form, and can originate from various professional services, e.g., medicine, nursing, social work, etc.

The most common type of ORC is the mobile clinic or traveling team. It is comprised of full-time VA staff who travel to specified locations on a part-time basis (monthly, bi-weekly, weekly, etc.) to deliver services to veterans who have difficulty getting to a VA health care facility. Clinics may be held in churches, service organization facilities, community care homes, state nursing homes or other locations. Traveling teams also include medical specialists who fly to remote areas to provide health care services and/or consultation on a part-time basis.

Since 1986, various types of SOCs, CBCs and ORCs have opened. These ambulatory care operations range from such activities as full time medical, surgical and psychiatric services to part time screening, post-hospital follow-up care, and outreach services to the homeless and the addicted. Although clinics have opened in both urban and rural areas, there has been greater activity in rural states.

Our planning criteria and standards encourage new SOCs to be established 75 or more miles from a VAMC, while CBCs should be located 100 or more miles from a VA medical center. With a few exceptions, ORCs are generally conducted within 100 miles of a VA facility, since the major form of outreach is a mobile team and the convenience and economies of staff travel from the home base VA medical center must be considered.

Over the last few years, ORC activities increased significantly, in contrast to the smaller number of new SOCs and CBCs. During the last four years VHS&RA has activated 111 ORCs, 21 CBCs and 4 SOCs. Through September 1989, the total number of clinics operated by VHS&RA includes, 169 ORCs, 53 CBCs and 35 SOCs.

The survey indicated that 6 SOCs, 18 CBCs and 36 ORCs are located over 100 miles from a VA facility. Some of the most remote areas, 200 miles or more from a VAMC, were being served by 3 CBCs (Farmington, NM, Redding CA, and McAllen, TX) and 6 outreach programs (2 specialty fly-in clinics in Billings and Miles City, MT; 2 mobile teams that travel to the far counties of Minnesota for psychiatric follow-up; and 2 small primary clinics or outposts in Caribou, ME and Fairbanks, AK). Another outreach clinic is being planned in rural North Dakota, but has not yet been implemented.

Recently, in its report on FY 1990 appropriations, the House Appropriations Committee identified the Eastern Kentucky area as an area of VA underservice. We are currently preparing a report to the Committee outlining our review of the pertinent factors involved. We hope to release this report to Congress in the near future.

MEDIPP Plans submitted in 1988 and 1989 included proposals for several clinics that have been deferred for future consideration pending funding availability.

Locating a small CBC or ORC more than 100 miles from a responsible VA facility presents particular challenges with respect to staff training, continuing medical education, quality assurance, communication, and supervision. As a result, Mr. Chairman, maintaining and establishing VA clinics in remote areas requires close monitoring and evaluation. In some locations veterans might be better served, at less cost, by our simply organizing a veterans' transportation network to the nearest VA medical facility. Other options and alternatives, such as fee-basis care, sharing agreements with DOD and community providers, and other creative arrangements, are being given increased attention in VA planning.

Later this morning you will receive testimony on our demonstration project in Redding, CA. We are very pleased with the success and community response to both the Redding and Farmington projects. An evaluation of the projects which focuses on improving access to care, quality of care, cost, patient satisfaction and staff morale, is proceeding as planned. We think these projects will provide us invaluable information for improving access to health care for veterans living in remote areas. I hope this committee will be interested in this evaluation and will consider its results in future legislative and oversight matters concerning rural care.

SUMMARY

Mr. Chairman, we believe a veteran's chosen place of residence, whether urban or rural, should not be a bar to access to VA care and services. As indicated, VA medical services are being extended to veterans in nearly every corner of the country. There remain some areas of underservice, and as we become more aware of these, innovative VA programs can be deployed to address particular problems. However, in this era of Federal spending restraint, we must take care to exercise carefully the taxpayers' contributions to VA appropriations, and, while sustaining quality, we must systematically plan for the most effective utilization of limited health care resources. I am sure this Committee clearly understands the limits of our financial resources. With your guidance and appropriate recommendations, I trust you will help us best deploy VA resources to meet our common priorities. We believe this is the best way to proceed, both for the Department and for the Congress.

Mr. Chairman, this concludes my formal statement. We will be pleased to address your and other Committee members' questions.

VA MEDICAL CARE EXPENDITURES
FY 1988, SELECTED STATES

In June 1989, VA provided the Senate Veterans' Affairs Committee an analysis of expenditures for states represented by members of the Committee. States with large veteran populations not represented by members of the Committee were included for comparison purposes. In addition, data on two states were added because of the members' perception of inequity of access to care for their rural veteran populations.

The VA spent nearly $11.3 billion in health care in FY 1988, exclusive of the Philippine Islands. The per capita average expenditure for all veterans was $413.75 with an average outpatient visit rate of 850 visits per 1000 veterans.

States with the largest veteran populations and their expenditures and visit rates are as follows:

STATE	TOT. EXPEND. (MILLIONS)	PER CAPITA EXPENDITURE	OPC VISITS PER 1000 VETERANS
California	$1,044.1	$365.44	1,030
New York	869.0	474.35	1,200
Texas	668.4	382.63	820
Illinois	547.5	438.88	940
Pennsylvania	508.6	333.75	650
Florida	497.3	330.16	840
Missouri	283.0	447.37	920

Those states with small veteran populations which could be classified as "rural states" reveal the following experience:

STATE	TOT. EXPEND. (MILLIONS)	PER CAPITA EXPENDITURE	OPC VISITS PER 1000 VETERANS
Wyoming	$36.6	$ 664.11	1,080
Alaska	60.2	976.12	1,430
Vermont	38.7	602.10	1,370
South Dakota	79.1	1,023.95	2,390
Hawaii	28.7	286.73	730
Montana	33.4	331.25	760
Maine	49.7	322.71	770

Four of the high veteran population states have visit rates above the national average, but only three states have per capita expenditures exceeding the average of $413.75. Of the low veteran population states, four have visit rates considerably higher than the national average (1.5 to 2.8 times the rate), and the same four states have expenditures above the national per capita average (1.4 to 2.8 times the average of $413.75).

FY 1988 EXPENDITURES FOR MEDICAL CARE
SELECTED STATES

U.S. AND STATES	VET. POP. (THOUSANDS)	VET. POP. SC 1/ (HUNDREDS)	TOTAL 2/ EXPENDITURES (MILLIONS)	PER CAPITA EXPENDITURES	OPC 3/ VISITS PER 1000 VETS
United States	27,299.1	2,198.8	$ 11,295.0	$ 413.75	850
Alaska	61.7	4.7	60.2	976.12	1,430
Arizona	414.8	39.6	158.9	383.23	1,130
California	2,857.9	198.9	1,044.1	365.34	1,030
Florida	1,506.4	161.1	497.3	330.16	840
Hawaii	100.4	9.0	28.7	286.73	730
Illinois	1,247.7	60.9	547.5	438.88	940
Maine	153.7	14.1	49.7	323.71	770
Missouri	632.8	39.6	283.0	447.37	920
Montana	100.9	8.3	33.4	331.25	760
New York	1,832.0	146.9	869.0	474.35	1,200
Pennsylvania	1,523.9	110.3	508.6	333.75	650
So. Carolina	353.9	27.9	122.3	345.64	710
So. Dakota	77.3	6.3	79.1	1,023.95	2,390
Texas	1,746.9	152.4	668.4	382.63	820
Vermont	64.3	4.9	38.7	602.10	1,370
West Virginia	220.1	18.8	129.5	588.51	1,490
Wyoming	55.2	4.0	36.6	664.11	1,080

1/ Excludes 0 percent SC not drawing compensation.
2/ Includes Puerto Rico; Excludes Philippine Islands.
This includes medical care, medical administration and miscellaneous operating expenses, medical and prosthetic research and general operating expenses.
3/ Staff and fee visits.

ANALYSIS OF WORKLOAD BY CATEGORY OF ELIGIBILITY

Veterans who are in "Category A" eligibility (service-connected, former prisoners of war, WWI and poor veterans) are considered mandatory inpatient workload by VHS&RA. Veterans who fall in Categories B and C are considered discretionary. That is, when patient care demand strains available VA resources, mandatory workload takes precedence and discretionary workload is referred to the private sector. Many times when there is public awareness of constrained VA resources, some veterans do not apply. This appears to be the case for FY 1989 compared to FY 1988 in recorded VA workloads.

The following tables indicate the degrees to which Categories B and C veterans generated inpatient and outpatient VA workloads in VA facilities during the two fiscal years. Also shown are the consequences of the applications for care of B and C Category veterans during the same two fiscal years.

INPATIENT

CATEGORY B AND C HOSPITAL DISCHARGES BY HOME STATE, FYs 1988 AND 1989 [1/]

STATE	CATEGORY B		CATEGORY C	
	1988	1989	1988	1989
Alaska	207	172	468	366
Arizona	752	456	475	285
California	3,473	2,098	2,691	1,744
Florida	1,370	1,299	949	715
Hawaii	41	37	24	19
Illinois	2,203	1,542	1,637	833
Maine	106	82	63	58
Missouri	1,024	363	855	274
Montana	246	150	159	104
New York	2,625	2,250	1,772	1,331
Pennsylvania	676	690	364	305
S. Carolina	660	563	306	210
S. Dakota	322	235	404	90
Texas	2,271	1,865	1,654	1,220
Vermont	121	34	91	48
West Virginia	296	250	192	126
Wyoming	184	69	166	54

[1/] File 94 percent complete as of November 27, 1989.
Source: VA Patient Treatment File, FY 1988; FY 1989

South Dakota, Vermont and Wyoming experienced the greatest reductions. These are also states which have high per capita expenditures and high OPC visit rates beyond the national average. Florida and Hawaii experienced the lowest change, approximately 14 percent.

OUTPATIENT

CATEGORY B AND C AMBULATORY VISITS BY HOME STATE, FY 1988 AND 1989 1/

STATE	CATEGORY B		CATEGORY C	
	1988	1989	1988	1989
Alaska	1,431	807	3,032	1,420
Arizona	12,029	8,748	7,566	5,463
California	78,092	53,644	67,170	43,914
Florida	20,665	21,824	16,642	14,605
Hawaii	795	711	449	477
Illinois	51,285	35,538	37,257	22,449
Maine	1,834	1,761	1,140	910
Missouri	15,829	5,627	12,948	5,009
Montana	2,274	1,211	1,428	711
New York	63,128	55,646	39,678	32,271
Pennsylvania	16,618	16,504	8,920	7,318
S. Carolina	8,017	6,729	3,940	2,472
S. Dakota	5,113	3,807	5,889	2,075
Texas	35,712	28,320	25,861	20,240
Vermont	2,447	603	2,228	813
West Virginia	4,422	3,150	2,347	1,576
Wyoming	2,352	947	3,054	1,201

1/ File 94 percent complete as of November 27, 1989.
Source: VA Outpatient Staff File, FY 1988; FY 1989

Alaska, South Dakota, Vermont and Wyoming reduced visits by 30 percent to 50 percent of the 1988 rates. Pennsylvania experienced 7 percent fewer visits in these categories while Florida and Hawaii dropped 3 percent to 5 percent in these categories.

PERCENT APPLICATIONS PROCESSED FOR MEDICAL CARE
BY ELIGIBILITY CATEGORY
1988 AND 1989

STATE	PERCENT CAT. A		PERCENT CAT. B		PERCENT CAT. C	
	1988	1989	1988	1989	1988	1989
USA	92.57	95.46	3.68	2.71	2.72	1.84
ALASKA	71.14	77.55	9.61	6.48	19.25	15.97
ARIZONA	93.76	95.20	1.22	3.03	0.91	1.78
CALIFORNIA	92.83	95.58	3.86	2.41	3.30	2.02
FLORIDA	95.23	95.22	2.61	2.81	2.14	1.98
HAWAII	96.04	94.99	2.06	2.26	1.90	2.76
ILLINOIS	91.68	93.76	4.58	3.65	3.73	2.59
MAINE	94.59	95.42	2.88	2.88	2.53	1.69
MISSOURI	91.44	97.09	4.16	1.63	4.38	1.28
MONTANA	90.10	94.69	4.17	2.82	5.62	2.49
NEW YORK	92.47	93.41	4.74	4.61	2.78	1.99
PENNSYLVANIA	95.41	95.68	2.43	2.32	2.14	1.99
S. CAROLINA	94.38	95.95	3.82	3.11	1.79	0.94
S. DAKOTA	89.73	94.54	4.36	3.17	5.89	2.30
TEXAS	94.08	94.73	3.39	3.43	2.51	1.85
VERMONT	86.13	96.85	7.89	1.30	5.97	1.86
W. VIRGINIA	95.16	96.71	2.77	2.01	2.05	1.28
WYOMING	90.52	97.95	4.39	2.21	5.08	3.51

Source: VA AMIS Report on Applications for Care, FY 1988; FY 1989

EQUITY OF ACCESS TO CARE

Outpatient care has been one of the fastest growing VA activities in recent years. At a system level, during FY 1987, veterans made almost 19.8 million visits to VA facilities for outpatient care. In FY 1988, total visits rose to over 21 million. However, for Categories B and C patients, there is a general trend of decreases in outpatient visits. This is due to constraints on VA health care resources, the well-known operating fund shortfall, and the ever more urgent need for VA practitioners to prioritize the deployment of VA medical care services for veterans with the highest eligibility for care. In this process--a type of "rationing"--Category B and C patients may be underserved and many referred to other available resources in the community. For example, in the 17 states listed in preceding tables both hospital discharges and outpatient visits have significantly decreased for Category B and C patients between FY 1988 and 1989.

Outpatient services to veterans provide pre-screening and follow-up visits for inpatient episodes of care, as well as ambulatory care which obviates the need for inpatient care. Thus, ambulatory care is not only efficient, but also it often avoids other, more expensive modes of care, and is itself a safe and clinically efficacious mode of care.

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TESTIMONY OF

ROBERT T. VAN HOOK, EXECUTIVE DIRECTOR

OF THE

NATIONAL RURAL HEALTH ASSOCIATION

on

HEALTH CARE FOR VETERANS

IN RURAL AREAS

Before the

SENATE COMMITTEE ON

VETERANS' AFFAIRS

November 15, 1989

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Mr. Chairman and Members of the Senate Veterans' Affairs Committee:

My name is Robert T. Van Hook and I am the executive director of the National Rural Health Association (NRHA). NRHA is a national, non-profit membership organization. Its primary goal is to improve health care services for rural Americans. NRHA's constituency is composed of individuals and organizations that have rural health interests and provide leadership on rural health issues through advocacy, communication, education and research.

Prior to addressing the issue of the availability of health care services to veterans living in rural America, I would like to take a few minutes to discuss current rural health legislative initiatives.

Until mid-October, it appeared that 1989 would be a banner year for rural health. However, on Friday, October 13th, hope began to fade for the enactment of a 1989 rural health package. On that day, the full Senate decided to strip down the 1989 Reconciliation Bill, thus eliminating an excellent rural health initiative and many other significant health provisions. The rural health package contained a 3% update for rural hospitals, expansion of the Rural Health Clinics Act, an innovative approach for physician payment reform, funding for states to establish offices of rural health, and a call for the elimination of the urban/rural differential that exists for standardized Medicare payments.

Due to the likelihood that a rural health initiative will not become law by the end of this Congressional session, the National Rural Health Association strongly urges both the House and Senate to introduce and pass an omnibus rural health bill in 1990. Such a proposal should contain many of the items that I mentioned earlier in my testimony. NRHA looks forward to working with all of you in seeing that an omnibus rural health bill is enacted by this time next year.

The focus of today's hearing concerns the availability of health care services to veterans living in rural America. Rural health care is beset by a number of problems which have an impact on the care available to rural veterans:

DISCRIMINATORY MEDICARE PAYMENTS: Rural hospitals are systematically paid approximately 35% less than their urban counterparts for the same service.

DECLINING INPATIENT UTILIZATION: Rural hospitals have seen significantly lower inpatient volumes. Between 1979-1985, rural hospital admissions dropped by 22.1% while urban hospital admissions rose by 1.1%.

LESS VIABLE RURAL HOSPITALS: Since the advent of the Prospective Payment System in 1983, rural hospital closures have increased dramatically. Most rural hospitals are losing money on their Medicare patients.

SHORTAGES OF HEALTH PROFESSIONALS: Shortages exist in nearly every health profession which threatens the continued availability of health care services in rural areas.

As a result of these and other problems, rural health care is in a state of unprecedented change. Services are being developed to meet the new environmental realities. There is a new impetus to try to meet the special needs of defined populations such as rural veterans.

The Veterans Administration currently operates over 170 hospitals with 80,000 beds, approximately 100 nursing home units, and some 200 outpatient clinics. In addition to these facilities, the Veterans Administration (VA) also provides contract care services with non-VA hospitals and community nursing homes. The demand for VA services continues to grow. Various reports have indicated that the number of veterans 65 years and older will triple from 3 million in 1980 to 9 million by the year 2000.

Congress expressed concern over the problems of rural veterans in 1984. The Veterans Health Care Act of 1984 directed the Veterans Administration to develop information on eligibility for VA services in remote rural areas and to develop alternative approaches for providing such care. The report, entitled Health Care for Veterans in Remote Areas, concluded that the VA had developed some outreach programs for veterans living in remote areas. These included:

Mail Prescription Program: Many prescriptions can be distributed by mail. Although the program eliminates access barriers, it does not give the individual the face-to-face option of asking questions and receiving answers about their prescriptions.

Hospital Based Home Care: This program allows veterans who would otherwise be hospitalized or in nursing facilities to remain in their own homes. This concept has been applied to remote rural areas. One medical center has established two satellite programs and another provides home visits to veterans living up to 75 miles from the VA hospital center.

Medical District Initiated Program Planning: This allows the local community to be responsive to the needs of veterans through identification of those needs combined with utilization of services available through the community. This process has been instrumental in expanding long-term care.

This 1986 report also emphasized the importance of utilizing community health centers, community mental health centers and the Indian Health Service in providing health care ervices to veterans. It should be noted that these three programs have demonstrated their effectiveness in providing health care to thousands living in underserved areas.

The report also discussed the difficulty in providing outpatient services to veterans living in remote areas. This is a problem not only for veterans, but for many individuals living in rural America. One solution to the problem is to encourage more community-based and mobile services. These programs allow physician assistants, supervised by community physicians, to provide primary care. Nurses, psychologists, and social workers have also proven to be instrumental in providing care in rural areas. These health providers can offer services that include psychiatric and preventative screening, referrals, and follow-up care upon being discharged from larger medical facilities. Needed specialists can provide care through various mobile clinics that are available in the remote communities once a month. This concept was used in North Dakota for many years and was recently disbanded due to lack of federal funds.

Another solution to serving outpatient needs is telecommunications. Through a telecommunications program that uses a computer and various other devices, individuals can receive follow-up care for various disorders involving rehabilitation.

As I stated earlier, the problems revolving around the delivery of health care services to veterans living in rural America do not differ from those of many individuals residing in rural areas. We need to focus on several issues in order to provide better health care services to veterans and all Americans living in rural localities:

NATIONAL HEALTH SERVICE CORPS: I indicated earlier that community health centers are very important in providing health care to rural Americans. Many centers are dependent on NHSC physicians. The Corps has been severely depleted during the last decade. Next year, the NHSC is up for reauthorization. It is very important that Congress increase both the NHSC scholarship and loan repayment program.

FLEXIBILITY IN AGENCY POLICY: The 1986 report cited this as being most critical for improving care to veterans living in remote areas. Circumstances differ from one place to another. The VA must be flexible in responding to the various needs of the local community.

COORDINATION OF VARIOUS PROGRAMS: Both the Veterans Administration and the Department of Health and Human Services

provide many programs that benefit many rural citizens, such as home health care and community health centers. It is important that these two agencies work with one another in making the most of their respective programs.

SUPPORT OF H.R. 1742, REIMBURSEMENT FOR REASONABLE COSTS FOR VETERANS RECEIVING MEDICAL CARE AT LOCAL HOSPITALS: Rep. Wes Watkins of Oklahoma recently introduced this legislation. This initiative would: enhance the availability of health care services to veterans living in rural areas, would help rural hospitals that have excess capacity, and it would save on future construction costs for more VA hospitals. Rural veterans could be cared for in rural localities to the benefit of veterans.

Veterans and all who reside in rural areas are encountering difficulty in gaining access to health care services. There is no simple solution to the problem. We must explore all opportunities and tailor those options to the needs of individual communities.

Thank you for the opportunity of testifying before this Committee.

STATEMENT OF
GEORGE ANDRIES, DIRECTOR
VA MEDICAL CENTER
CHEYENNE, WY

I would like to thank the Committee for inviting me to discuss the provision of rural health to veterans. Coming from the state which Senator Simpson describes as the land of high altitude and low multitude, the problems which the Cheyenne VA Medical & Regional Office Center and the Sheridan VA Medical Center face in providing rural health are typical of those faced by the other Centers in the rural west. Wyoming is the ninth largest state in the United States containing 97,914 square miles. To put this size in perspective, if one was to go from Cheyenne, Wyoming in the southeast to Jackson Hole, Wyoming, in the northwest, the scene of the recent mini-summit it would be equivalent to driving from Washington, D. C. to Manchester, New Hampshire. However, unlike the drive from Washington to Manchester the driver would go several stretches of over a hundred miles without going through any population centers and, in many instances, only seeing one or possibly two houses. Wyoming's population density of five persons per square mile is amongst the lowest in the country. Adding to this problem of huge distance and sparse population is the fact that there is no routine intrastate public transportation system in Wyoming, especially between the Cheyenne and the

other population centers in Wyoming. While one can reach several cities by air, one must always fly out of the state first. We must even send our patients to Denver, 120 miles, to meet the Air Force AirVac plane - even though there is an Air Force Base in Cheyenne down the street.

However, the need for veterans healthcare is great. Since I arrived in Cheyenne, Wyoming in 1986, the number of individual veterans applying for and receiving medical care at the Cheyenne VA Center has grown by 44.6% from 3,073 patients in 1986 to 5,544 in FY 89.

The need is even more dramatically demonstrated by the Cheyenne VA Center's experience during last year's fiscal crisis. Because of the financial problems faced by the Center, we were forced to restrict our care to only those veterans who had mandatory entitlement to VA treatment. Consequently, we restricted eligibility only to those veterans who were Category A eligible for inpatient care and for outpatient care to those veterans who were receiving treatment for their service-connected injuries; were service-connected over 30%; or were veterans, service-connected or

nonservice-connected, whose annual income was less than $10,338. As a result of this strict interpretation of law, the Cheyenne VA Center dropped 651 veterans from its care or 11% of its previous year's workload. All but 51 of the 651 veterans, that had been reluctantly dropped from our rolls, were replaced by veterans who were Category A or mandatorily eligible for care.

Though we do not have statistics for last year yet, our statistics for the previous year verify the findings of the 1985 VA Study of Healthcare Services of Veterans Living in Geographically Remote Areas. As the study notes, "The further away veterans live from a VA facility, the less likely they are to travel great distances for care particularly outpatient care." 84% of our total annual outpatient visits came from ten counties in Wyoming, eastern Nebraska, and Colorado which are within a 100 miles of Cheyenne. The remaining 12 counties including Natrona County which is the home of Casper, the second largest city in Wyoming, and which are all well over 150 miles from Cheyenne and the Sheridan VA Medical Center accounted for only 16% of our visits. Given the economic problems faced by the agrarian and oil and mineral

based economies of these Wyoming counties, there is no question that there remain a significant number of veterans who meet not only our current eligibility requirements but also the stringent eligibility requirements that we imposed last year. Yet, distance and lack of convenient public transportation prevents these veterans from utilizing these benefits. In the area of mental health, the problem of distance is compounded by the limited availability of professional care. For example, there are only 18 non-federal psychiatrists in the entire State of Wyoming.

Despite the challenges I have just described, I believe that there are cost effective actions that we can take and are taking to provide quality healthcare and veterans benefits to the geographically disbursed veterans in our two state Primary Service Area and northern Colorado. As one of the VA's nine combined Regional Office and Medical Centers, The VA has been able to reduce administrative costs by consolidating the overall supervision and administrative support for both the regional office and the medical Center. More importantly, locally, we have been able to utilize the resources of both

the Veterans Benefits Administration and the Veterans Health Services and Research Administration. For example, in the Riverton-Lander area on the Wind River Reservation, 275 miles from Cheyenne, we established a Native American Tribal Service Officer position in conjunction with the State of Wyoming, and the Department of Labor. This project which cost the VA nothing in terms of salary resulted in bringing over $650,000 worth of benefits to the veterans on this reservation and moreover, has assisted over 219 of them to receive medical care benefits that they had never previously applied for.

We have also developed under MEDIPP, a plan to establish an outreach Clinic in Casper, Wyoming. Working with our affiliate the University of Wyoming Family Practice Residency Program, which already has a clinic in the Casper area, we believe that we can provide over 11,000 outpatients visits a year at a much lower cost than if we had to establish a totally free standing clinic and with a quality that is assured because of the on-site supervision by both the VA and the University. Moreover, by utilizing a trained Veterans Benefits Counselor to provide administrative support to the Outreach Clinic we

will be able to not only provide a qualtity healthcare presence in Wyoming's second largest city, but also at very low cost, an additional source of benefits information.

In summary, the Cheyenne and Sheridan VA's are facing problems in delivering healthcare in an area which features vast distances and sparse populations. Moreover, we face this problem with a transportation system that is virtually non-existent with the exception of privately owned vehicles. Regardless, the demand for healthcare is there and growing. By utilizing all the resources that exist within the Department of Veterans Affairs and by also developing creative collaborations with other Federal agencies, such as the Department of Defense and the Department of Labor, and state and local governments, and the University, we can create innovative solutions to these problems which will allow us to deliver quality healthcare and benefits to the veterans who live in rural areas. Since rural health is an issue that faces not only the VA but the private sector also, it is in the enlightened self-interest of all the parties involved to work together to meet this challenge.

STATEMENT OF
JIM DEREMO, SERVICE OFFICER
DEPARTMENT OF SOUTH DAKOTA
THE AMERICAN LEGION

I CONSIDER IT AN EXTREMELY GREAT HONOR AND PRIVILEGE TO APPEAR HERE BEFORE THIS COMMITTEE TODAY. THE ISSUE OF RURAL HEALTH CARE AS IT PERTAINS TO OUR VETERANS IS A CRITICAL ONE IN SOUTH DAKOTA, AND INDEED IN THE ENTIRE COUNTRY. AND IT IS AN ISSUE THAT HAS, IN RECENT YEARS BECOME EXTREMELY EXASPERATING TO MYSELF AND MY FELLOW SERVICE OFFICERS. FOR IN THE LAST SEVERAL YEARS WE HAVE WITNESSED WHAT WE, AND THOUSANDS OF OUR FELLOW VETERANS CONSIDER A BREACH OF FAITH BY OUR GOVERNMENT IN REGARDS TO HEALTH CARE.

LET ME JUST SAY AT THE OUTSET THAT IF I OFFEND ANYONE HERE TODAY I ASSURE YOU IT IS NOT INTENTIONAL. BUT, I DO FEEL VERY STRONGLY BY THAT THERE ARE THINGS THAT NEED TO BE SAID AND POINTS THAT NEED TO BE MADE ON BEHALF OF OUR VETERANS.

ONE OF THE MOST DASTARDLY DEEDS FORCED UPON OUR RURAL VETERANS RECENTLY WAS THE IMPLEMENTATION OF THE "MEANS TEST." THIS LAW, IN EFFECT, ELIMINATED ESSENTIALLY EVERY FARMER IN RURAL AMERICA WHO HAPPENS TO BE NON SERVICE-CONNECTED. BECAUSE OF THE $40,000.00 GROSS LIMIT ON ASSETS, ESSENTIALLY NO FARMER IS ELIGIBLE FOR VA MEDICAL CARE. IF A NON SERVICE-CONNECTED FARMER EVEN HAS A TRACTOR PAID FOR, HIS ASSETS FOR VA MEDICAL CARE PURPOSES WOULD BE EXCESSIVE AND PUT HIM IN CATEGORY "C". AND YET HE MAY HAVE A DEBT AGAINST HIS LAND IN EXCESS OF THE VALUE OF THAT LAND. THIS SAME FARMER, HAVING HONORABLY SERVED HIS COUNTRY DURING A TIME OF WAR, HAVING BELIEVED THAT HIS COUNTRY WOULD HONOR ITS' PROMISE OF NEEDED MEDICAL CARE AND DID NOT OR COULD NOT FINANCIALLY AFFORD TO PURCHASE HEALTH INSURANCE IS NOW TOLD

BY HIS COUNTRY THAT THE PROMISE MADE TO HIM TWENTY, THIRTY, FORTY OR MORE YEARS AGO WILL NO LONGER BE HONORED BY HIS COUNTRY. THIS COUNTRY THAT HE WILLINGLY SERVED, FOUGHT THROUGH THE MUCK, AND MUD, BLOOD AND GUTS AND GORE IS NOW TURNING ITS BACK ON HIM. SIMPLY BECAUSE HE WAS FORTUNATE AND DIDN'T GET WOUNDED OR DEVELOP HEMORRHOIDS THAT ARE NOW SERVICE CONNECTED HIS COUNTRY WILL NOT ALLOW HIM TO BE TREATED AT THE VA. GENTLEMEN, I WOULD LIKE TO TELL YOU ABOUT A FRIEND OF MINE. HE IS A WW II VETERAN. HE SERVED IN THE PACIFIC AND SAW SOME OF THE FIERCEST FIGHTING OF THE WAR. HE WASN'T WOUNDED OR HURT. HE CAME BACK HOME, WENT TO WORK AND THROUGH A LOT OF SWEAT AND TOIL HE MANAGED TO BUILD A SMALL BUSINESS IN RURAL SOUTH DAKOTA. HE HAS BELIEVED FOR FORTY PLUS YEARS THAT IF HE EVER NEEDED MEDICAL CARE HE COULD GO TO THE VA. FORTUNATELY, HE ENJOYED GOOD HEALTH UNTIL RECENTLY WHEN HE FOUND OUT THAT HE HAD A SERIOUS CIRCULATORY PROBLEM. WHEN HE WENT TO THE VA A COUPLE OF YEARS AGO HE WAS TOLD HE WOULD HAVE TO PAY TWENTY ONE DOLLARS IF HE WANTED TO SEE A DOCTOR. ALTHOUGH HE FELT THAT BECAUSE HE HONORED HIS COUNTRY FORTY YEARS AGO, HIS COUNTRY WOULD NOW HONOR HIM BY PROVIDING THE MEDICAL CARE HE NEEDED, HE WOULD PAY. THAT'S WHEN HE FOUND OUT ABOUT THE CIRCULATORY PROBLEM THAT COULD LEAD TO A STROKE. THE VA STARTED TREATING HIM AND IN FACT HE WAS SCHEDULED FOR SURGERY. AND THEN, ALL OF A SUDDEN THE CATEGORY "C" CARE WAS TERMINATED. ALL OF A SUDDEN, MY FRIEND IS OUT. NO MEDICINE, NO DOCTOR VISITS, AND NO SURGERY. BECAUSE HE MISTAKENLY THOUGHT HE WOULD ALWAYS BE ABLE TO GO TO THE VA, HE DID NOT PURCHASE HEALTH INSURANCE. HE HAS A MEDICAL PROBLEM THAT IS LIFE-THREATENING. HE CAN'T AFFORD PRIVATE HEALTH INSURANCE AND CAN 'T GO TO THE VA. THE ONLY WAY HE

WILL EVER BE ABLE TO GO TO THE VA AGAIN, AS THINGS PRESENTLY STAND, IS IF HE EITHER GIVES EVERYTHING AWAY HE HAS WORKED FOR OVER THE LAST FORTY YEARS OR JUST SPENDS IT ALL WASTEFULLY. THIS IS ABSOLUTELY RIDICULOUS! A TRAVESTY! MY FRIEND ISN'T A BUM. HE ISN'T A DRUNK. HE ISN'T LAZY. HIS ONLY FAULT IS THAT HE PUT HIS FAITH IN HIS GOVERNMENT.

I COULD GO ON FOR HOURS, TELLING ABOUT THE HUNDREDS OF VETERANS IN OUR AREA WHO HAVE BEEN TREATED LIKE MY FRIEND. BUT SUFFICE IT TO SAY THAT THERE ARE THOUSANDS OF VETERANS IN RURAL AMERICA THAT ARE EXTREMELY DISAPPOINTED IN THEIR GOVERNMENT. VETERANS, GENERALLY SPEAKING ARE NOT NOW, NOR HAVE THEY EVER BEEN LOOKING FOR A HAND-OUT; SOMETHING FOR NOTHING..... BUT THEY DO EXPECT PEOPLE TO KEEP THEIR PROMISES, BE THEY WRITTEN OR IMPLIED. OUR GOVERNMENT, HASN'T DONE THAT.

IN RURAL SOUTH DAKOTA ALTERNATIVE MEDICAL CARE JUST IS NOT AVAILABLE. IN URBAN AREAS THERE ARE COUNTY HOSPITALS AVAILABLE. IN SOUTH DAKOTA, AND I SUSPECT, IN MOST OTHER RURAL AREAS, ALTERNATIVE INDIGENT CARE IS NOT AVAILABLE. SO, THOSE VETERANS WHO, FOR WHATEVER REASONS ARE UNABLE TO GET THEIR MEDICAL NEEDS TENDED TO BY THE VA HAVE NO ALTERNATIVE OTHER THAN GETTING THE CARE LOCALLY AND THEN BEGGING THEIR COUNTY TO PAY FOR IT THROUGH THE COUNTY INDIGENT (WELFARE) HEALTH CARE FUND. IN SOUTH DAKOTA, SINCE THE ADVENT OF THE MEANS TEST AND SUBSEQUENT TERMINATION OF TREATING CATEGORY B AND C VETERANS THERE HAS BEEN A DRASTIC RISE IN THE NUMBER OF VETERANS REQUESTING THEIR

COUNTY TO PAY FOR THEIR HEALTH CARE. AND THE COST IS BECOMING UNBEARABLE TO THE COUNTRY. I FIND IT PERSONALLY REPREHENSIBLE THAT ANY VETERAN WOULD HAVE TO GO BEGGING FOR HEALTH CARE. BUT BECAUSE THE VA HAS A POLICY OF TERMINATING CARE TO THE SO-CALLED "STABLE" PATIENTS, MANY THOUSANDS OF VETERANS HAVE BEEN FORCED TO DO JUST THAT.....BEG! THEY ARE TOLD THAT THEIR MEDICAL CONDITION IS NOW "STABLE" AND SO THEY ARE BEING KICKED OUT OF THE VA HEALTH CARE SYSTEM. AND THE DECISION AS TO WHETHER THE CONDITION IS STABLE IN MANY CASES IS BEING MADE BY ADMINISTRATIVE PEOPLE INSTEAD OF DOCTORS OR OTHER HEALTH CARE PROFESSIONALS. THE BOTTOM LINE COMES DOWN TO MONEY. THE MAJOR QUESTION IN THE VA NOW SEEMS TO BE HOW SOON CAN A VETERAN BE KICKED OUT THE DOOR SO THE VA CAN SAVE SOME MONEY. I THINK IF YOU TALK TO ANY DOCTOR YOU WOULD BE TOLD THAT THIS IS JUST NOT GOOD HEALTH CARE. AND ONCE THE VETERAN HAS HIS CASE TERMINATED, THEN WHAT IS HE TO DO? HE DOESN'T HAVE ANY HEALTH INSURANCE, HE DOESN'T HAVE THE FINANCIAL ABILITY TO PAY FOR PRIVATE MEDICAL CARE, AND HE IS TOO PROUD TO BEG HIS COUNTY TO PAY FOR IT. SO HE JUST DOESN'T GET THE MEDICAL CARE HE NEEDS. SO HE BECOMES "UNSTABLE" VERY SICK, ENDS UP IN CRITICAL CONDITION EITHER AT THE VA OR IN A PRIVATE HOSPITAL WITH THE COUNTY HAVING TO PAY FOR IT OR THE VA SPENDING THOUSANDS OF DOLLARS TO TREAT HIM, WHEN, IF THEY WOULD HAVE JUST PROVIDED THE MEDICATION HE NEEDED TO KEEP HIM STABLE, THIS WHOLE FIASCO COULD HAVE BEEN AVOIDED. AND THIS IS A CONSISTENT SCENARIO IN THE VA MEDICAL CARE SYSTEM. I HAVE TALKED TO MANY VETERANS WHO HAVE BEEN "STABILIZED" AT THE VA AND THEN HAD THEIR CARE TERMINATED WHO HAVE TAKEN THEIR $3-400.00 PER MONTH SOCIAL SECURITY CHECK TO BUY THEIR MEDICATION PRIVATELY AND THEN

WILL GO WITHOUT FOOD, HEAT, CLOTHING OR SOME OTHER NECESSITY AND THEN HAVE TO BEG FOR FOOD STAMPS, RENT ASSISTANCE OR SOME OTHER THING FROM ANOTHER GOVERNMENT AGENCY JUST TO SURVIVE. SO WHAT HAS REALLY BEEN SAVED BY THE GOVERNMENT, I.E. THE VA? ABSOLUTELY NOTHING. IN FACT, IT IS PROBABLY COSTING THE GOVERNMENT, AS A WHOLE, MORE MONEY TO OPERATE THIS WAY IN THE LONG RUN. BUT I GUESS, IF A VETERAN IS TURNED AWAY FROM THE VA AND JUST GOES HOME AND DIES, THE GOVERNMENT DOES SAVE MONEY THAT WAY, WHICH IS WHAT HAPPENED TO ONE OF OUR CLIENTS WITHIN THE LAST YEAR. HE WAS BEING FOLLOWED, AS A CATEGORY "C", FOLLOWING HEART BY-PASS SURGERY. HE WAS TOLD THAT BECAUSE HE WAS A CATEGORY "C" HE WOULD NOT BE ABLE TO COME TO THE VA ANY MORE. ABOUT A MONTH AFTER HE RECEIVED HIS TERMINATION NOTICE, HE DIED OF A HEART ATTACK. WOULD HE HAVE LIVED IF THE VA HADN'T TERMINATED HIS CARE? WHO KNOWS! HOWEVER, AT LEAST HE WOULDN'T HAVE DIED FEELING HIS COUNTRY HAD DESERTED HIM. AND THE IRONIC PART OF THIS STORY IS THAT THIS PARTICULAR VETERAN HAD BEEN AWARDED TWO PURPLE HEARTS DURING WW II. BUT HE HAD NEVER APPLIED FOR A SERVICE CONNECTED DISABILITY BECAUSE OF HIS WAR WOUNDS. THE GOVERNMENT HAD SAVED PROBABLY HUNDREDS OF DOLLARS OVER THE FORTY PLUS YEARS SINCE HE WAS WOUNDED BECAUSE HE HAD NEVER APPLIED FOR SERVICE CONNECTION. HE WAS DISCHARGED, WENT HOME, AND MADE HIS OWN WAY. BUT WHEN HE NEEDED HELP, HE WENT TO THE VA AND THEY TOLD HIM HE WASN'T ELIGIBLE FOR CARE BECAUSE HE HAD MADE SOMETHING OUT OF HIS LIFE AND UNFORTUNATELY FOR HIM, HAD ACCUMULATED TO MANY ASSETS. HAD HE GOTTEN DISCHARGED AND BEEN A BUM, OR HAD HE APPLIED FOR COMPENSATION AND MADE THE VA PAY HIM EVERY MONTH, HE WOULDN'T HAVE BEEN TURNED AWAY.

IN SOUTH DAKOTA, AS IN MOST RURAL COMMUNITIES OF THE COUNTRY, ADEQUATE MEDICAL CARE IS JUST NOT THERE. IN SOUTH DAKOTA THERE IS A REAL NEED FOR THE DEVELOPMENT OF A COMPREHENSIVE RURAL HEALTH CARE PROGRAM. ACCESSIBILITY AND AVAILABILITY IS THE KEY, IT SEEMS TO ME. A PERSON LIVING IN RURAL SOUTH DAKOTA MAY IN MANY INSTANCES HAVE TO TRAVEL 2-300 MILES FOR CARE. IN RECENT YEARS CLINICS AND HOSPITALS HAVE BEEN FORCED TO CLOSE. THIS HAS COME ABOUT FOR SEVERAL REASONS. BUT THE BOTTOM LINE IS THAT ADEQUATE MEDICAL CARE JUST ISN'T AVAILABLE IN THE RURAL AREAS. IT WOULD SEEM TO ME THAT THIS MATTER NEEDS TO BE ADDRESSED BOTH FOR VETERANS AND NON VETERANS ALIKE. AND, IT SEEMS THAT THE VA COULD LEAD IN THIS AREA. IN LARGER URBAN AREAS THERE ARE COUNTY HOSPITALS AND CLINICS. RURAL AMERICA HAS, FOR THE MOST PART BEEN UNABLE TO MEET THE NEEDS OF ITS PEOPLE IN REGARDS TO MEDICAL CARE. AS FAR AS OUR VETERANS ARE CONCERNED IT WOULD SEEM TO ME THAT ADEQUATE RESOURCES COULD BE AVAILABLE TO FORMULATE A RURAL OUT-PATIENT TREATMENT PROGRAM FOR VETERANS. INSTEAD OF SPENDING $40,000.00 TO TEAR OUT AND REPLACE DOORS AND $70,000.00 FOR CLASSROOMS, AND $100,000.00 PLUS FOR EQUIPMENT THAT REALLY ISN'T NEEDED, IT WOULD SEEM TO ME, AND A LOT OF OTHER VETERANS, THAT THE MONEY COULD BE BETTER SPENT ON INSURING THAT VETERANS WHO NEED CARE CAN GET IT. GENTLEMEN, LET ME JUST TELL YOU IN SOME DETAIL, WHAT I'M TALKING ABOUT. AS YOU ALL KNOW, RECENTLY, A SUPPLEMENTAL VA BUDGET WAS PASSED. AT ONE OF THE VA HOSPITALS IN SOUTH DAKOTA $40,000.00 WAS USED TO TEAR OUT THE FRONT DOORS OF THE CLINIC AND REPLACE THEM WITH A NEW REVOLVING DOOR. NOW, WE WERE TOLD THAT THIS WAS DONE TO CONSERVE ENERGY AND NO DOUBT

IT WILL. THE OLD DOORS HAD BEEN THERE FOR SEVERAL YEARS AND REPLACING THE DOORS WAS NEVER SUCH A TOP PRIORITY. THEN ALONG COMES THE SUPPLEMENTAL BUDGET AND BOOM, WE'RE GETTING BRAND NEW $40,000.00 DOORS. NOW, THIS MIGHT SEEM LIKE AN INSIGNIFICANT AMOUNT TO THE VA OFFICIALS AND FROM THE ATTITUDE I'VE SEEN, THEY THINK SOMETHING LIKE THIS IS REALLY INSIGNIFICANT. IN FACT, WHEN I AND SOME OTHER SERVICE OFFICERS MADE AN INQUIRY INTO THE BUDGETARY PROCESS AT THIS FACILITY WE WERE TOLD IT WAS, AND I QUOTE, "NONE OF OUR DAMN BUSINESS. THIS IS MANAGEMENT AREA AND WHEN I (MEANING THE DIRECTOR) MAKE A DECISION YOU (THE SERVICE OFFICERS) WILL BE INFORMED." AT THIS SAME FACILITY $70,000.00 WAS SPENT BUILDING A CLASSROOM. AGAIN, THE QUESTION IS, "WHY IS THE VA SPENDING THIS KIND OF MONEY ON PROJECTS WHILE IT IS KICKING VETERANS OFF THE TREATMENT ROLES? IT SEEMS THAT THE MONEY COULD BE MUCH MORE PRODUCTIVELY SPENT TREATING VETERANS. IN RURAL SOUTH DAKOTA, AND I SUSPECT, IN OTHER RURAL AREAS, THE VA COULD DEVELOP AN OUT REACH PROGRAM THROUGH THE USE OF MOBILE MEDICAL VANS. THESE VANS COULD BE SET UP AT THE VARIOUS VETERAN ORGANIZATION POSTS AND CHAPTERS. WITH MOBILE MEDICAL VANS THE VETERANS, THAT THE VA IS SUPPOSED TO BE SERVING, COULD BE MUCH MORE ADEQUATELY SERVED. INSTEAD OF THEM HAVING TO DRIVE HUNDREDS OF MILES FOR MEDICAL CARE, THE MEDICAL CARE COULD COME TO THEM. WITH JUST THE TWO INSTANCES I MENTIONED, A TOTAL OF $110,000.00 COULD HAVE GONE A LONG WAY IN PROVIDING HEALTH CARE TO VETERANS IN RURAL AREAS. ONE VA MEDICAL FACILITY IN SOUTH DAKOTA OVER THE LAST YEAR TERMINATED CARE TO ABOUT 3,000 VETERANS IN THEIR PRIMARY SERVICE AREA. DOES THAT MEAN THAT THE NEED FOR MEDICAL CARE NO LONGER EXISTS? CERTAINLY NOT! IN FACT,

SINCE THEIR CARE WAS TERMINATED, AT LEAST A PORTION OF THEM HAVE NOT BEEN RECEIVING MEDICAL CARE AT ALL. SO A SERVICE LIKE THIS WOULD PROVIDE THEM WITH THE MEDICAL CARE THEY NEED. SECONDLY, IT WOULD ALLEVIATE THE NEED FOR VAST NUMBERS OF VETERANS TO TRAVEL VAST DISTANCES FOR CARE. AND HOW WOULD THIS BE PAID FOR? FIRST, IN MY OPINION, THE VA BUDGET, IF PROPERLY SPENT, WOULD ALLOW SUCH A PROGRAM TO BE IMPLEMENTED. INSTEAD OF SPENDING $40,000.00 ON REVOLVING DOORS THAT REALLY AREN'T NEEDED AND $70,000.00 CLASSROOMS THAT AREN'T NEEDED, IT COULD BE SPENT ON A PROGRAM SUCH AS I HAVE DESCRIBED. THE GSA HAVE AUTOMOBILES AVAILABLE SO THERE WOULD BE NO NEED TO EXPEND MONEY IN THAT AREA. THE VA SHOULD BE ABLE TO PICK UP SOME MONEY THROUGH THE THIRD PARTY BILLING PROGRAM IT ALREADY HAS IN PLACE. SO, THE VETERANS IN RURAL AMERICA GET THE HELP THEY NEED, THE VA PROVIDES A MUCH NEEDED SERVICE AND BASICALLY THERE IS NO COST INVOLVED. THE VETERANS I HAVE DEALT WITH ARE NOT OPPOSED TO THIRD PARTY BILLING. ALTHOUGH, THEY DO FEEL THAT THEIR CARE SHOULD BE PROVIDED BY THE VA, FREE OF CHARGE, THOSE WITH HEALTH INSURANCE COVERAGE, BY AND LARGE, ARE NOT OPPOSED TO THIRD. PARTY BILLING. WHAT THEY ARE ADAMANTLY OPPOSED TO IS THE MEANS TEST AND HAVING THEIR GOVERNMENT TELL THEM THEY DON'T DESERVE TO COME TO THE VA FOR THEIR HEALTH CARE BECAUSE AFTER THEY GOT OUT OF THE SERVICE THEY WENT BACK HOME AND MADE SOMETHING OF THEMSELVES AND ACCUMULATED TOO MUCH INCOME AND/OR ASSETS. ACCORDING TO THE 1980 CENSUS THE AVERAGE FARM INCOME WAS AROUND $8,000.00. THE PER CAPITA INCOME FOR THE ENTIRE STATE WAS AROUND $5,000.00. THIS FARMER WITH $8,000.00 INCOME CAN NOT GO TO THE VA BECAUSE HIS ASSETS WILL MOST LIKELY PUT HIM INTO CATEGORY "C"

EVEN THOUGH HE MAY HAVE, AND MOST LIKELY DOES HAVE, A HUGE DEBT AGAINST HIS FARM BUT HE MAYBE HAS A TRACTOR AND PLOW WORTH $40,000.00. WHAT THE GOVERNMENT VIA THE MEANS TEST HAS TOLD THIS FARMER IS THAT BECAUSE HE HAS A TRACTOR AND PLOW THAT ARE PAID FOR HE CAN NOT BE TREATED AT THE VA.....SO WHAT IS HE SUPPOSED TO DO FOR HIS HEALTH CARE?

SO, IN SUMMATION, THE PROBLEMS WITH THE RURAL HEALTH CARE, AT LEAST IN SOUTH DAKOTA, BOIL DOWN TO THIS. THE ACCESSIBILITY JUST ISN'T THERE. WE ARE SHORT OF DOCTORS IN THE RURAL AREAS AS I'M SURE YOU ARE ALL AWARE OF. HOSPITALS AND CLINICS ARE CLOSING BECAUSE THEY CAN'T STAY AFLOAT FINANCIALLY DUE TO RISING COSTS AND DECLINING REVENUES. OUR VETERANS THEN ARE LEFT WITH NO ALTERNATIVE. THEY CAN'T GET INTO THE VA AND OTHER MEDICAL FACILITIES AREN'T AVAILABLE. THEY DO NOT HAVE PRIVATE HEALTH INSURANCE. SO THEY SIMPLY DO NOT GET THE MEDICAL CARE. THE DISTANCE THEY HAVE TO TRAVEL ALSO CREATES PROBLEMS. IN RURAL SOUTH DAKOTA IT IS NOT UNCOMMON TO HAVE TO TRAVEL 100-200 MILES TO SEE A PRIVATE DOCTOR OR EVEN FURTHER TO GET TO A VA FACILITY. SOUTH DAKOTA IS ONE OF THE POOREST IF NOT THE POOREST STATE IN THE COUNTRY BASED ON PER CAPITA INCOME. ONE ONLY HAS TO SEE THE OVER ALL COSTS PAID FOR INDIGENT HEALTH CARE DURING THE LAST YEAR TO REALIZE THAT OUR CITIZENS CAN NOT AFFORD PRIVATE HEALTH CARE. LAST YEAR ALONE, OUR STATE PAID OUT ABOUT $4 MILLION FOR INDIGENT HEALTH CARE. AN ADDITIONAL $1.5 MILLION WAS SPENT FOR OTHER INDIGENT CARE. SINCE THE IMPLEMENTATION OF THE MEANS TEST AND TERMINATION OF CARE FOR CATEGORY B & C VETERANS OUR STATE HAS SEEN AN INCREASING NUMBER OF

VETERANS APPLYING FOR INDIGENT HEALTH CARE BENEFITS. AND WHILE THERE SEEMS TO BE MONEY IN THE VA BUDGET FOR $40,000.00 REVOLVING DOORS AND THE LIKE, IT COMPLETELY BEFUDDLES ME WHY, INSTEAD OF SPENDING MONEY LIKE THAT, THERE ISN'T MORE OF AN EFFORT PUT INTO FINDING MONEY TO CARE FOR OUR VETERANS MEDICAL NEEDS.

WOULD CONCLUDE BY SIMPLY STATING THAT WE ARE OPTIMISTIC. SECRETARY DERWINSKI IS A MAN WHO IS GENUINELY INTERESTED IN THE NEEDS OF OUR VETERANS. OUR HOPE IS THAT HIS EFFORTS WILL CONTINUE AND EVENTUALLY WE WILL HAVE A VA SYSTEM THAT CAN TRULY LIVE UP TO ITS MOTTO, "TO CARE FOR HIM WHO SHALL HAVE BORNE THE BATTLE, AND FOR HIS WIDOW AND ORPHAN."

STATEMENT OF RAYMOND L. SEERUP, DEPARTMENT COMMANDER
THE AMERICAN LEGION DEPARTMENT OF MONTANA
BEFORE THE COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE
NOVEMBER 15, 1989

Mr. Chairman and Members of the Committee:

It is a distinct honor for me as Department Commander of the American Legion of Montana to offer testimony on health care of veterans in rural areas.

The current crisis in rural health care impacts veterans in a number of states and is not a problem unique to veterans living in the sparsely populated "Old West" states such as Montana. Not being in an informative position to address rural health care of veterans nationwide, I will focus my testimony only on Montana and issues that affect veterans served by the VA within that state. I will be happy to refer any questions outside of the Montana area to our National American Legion Veterans Affairs and Rehabilitation staff for their prompt reply to the Committee.

DEMOGRAPHICS:

Montana:

A demographic profile of Montana is imperative to understand rural health care needs of veterans in the State of Montana.

(A) Montana has two VA Medical Centers, one at Fort Harrison in Helena, and one in Miles City. A shadow of Montana's land mass super-imposed on the east coast of the United States would cover five states and 37 VAMC's. The veterans in the Eastern Seaboard states have access to public transportation and alternative means for health care. Most veterans in Montana have neither.

(B) Montana's population is approximately 800,000 and contains more than 106,000 veterans. This means that one of every eight Montanans is a veteran.

(C) Montana has one of the highest ratios of total veterans to the total state population in the United States. By contrast, in FY's 87 and 88, Montana had one of the lowest VA health care expenditure-per-veteran allocations in the United States.

PRIMARY SERVICE AREA (PSA):

The following demographic profile of the Primary Service Area (PSA) is necessary to understand the uniqueness of the State of Montana in size as compared with other states. Montana is comprised of over 145,000 square miles. This area is nearly equally divided between the Fort Harrison PSA and the Miles City PSA.

(A) The VAMC in Miles City serves a veteran population of 45,000 spread over 77,000 square miles, an area larger than the states of North or South Dakota. The Miles City PSA includes all of easter Montana, western North Dakota, and the northern tier of counties in Wyoming.

(B) VA studies indicate that, on a nation-wide basis, 95 percent of all veterans live within a 100 mile radius of the nearest VA Medical Center. However, 83 percent of the veterans in the Miles City PSA live more than 100 miles from the medical center. In many cases, the two VA Medical Centers in Montana are the only medical facilities available to veterans.

(C) There are three Native American Reservations in the Miles City PSA. Reservations have one of the highest ratios of veterans to the total population of any sub-culture in the United States.

(D) With the exception of limited daily bus service, there is no public ground transportation in this PSA. The north-south axis serving the Native American Reservations has no public transportation whatsoever.

(E) The economy, which is predominantly agriculture, has been adversely depressed by several years of drought and the general decline in agriculture. In addition, the energy-related industry in the State of Montana has been severely depressed for the last five years with a high unemployment rate in the Yellowstone and Williston Basins.

VETERAN PROFILE:

The average profile for a veteran treated at the Miles City VAMC would be a 61 year old male with an income of less than 16,400 per year, who is employed in agriculture, retired on a limited fixed income, or unemployed. In FY 89, 93.2 percent of all veteran inpatients and outpatients applying for medical care at Miles were Category A. Category B (2.6 percent), and Category C (4.0 percent) were a mix of urgent or emergency cases.

COOPERATIVE ACHIEVEMENTS:

With the arrival of a new medical director at Miles City in late 1986, a new cooperative effort was enacted between the veterans service organizations and the VAMC. At the request of The American Legion of Montana, a meeting was held with the new director, James A. Huff, and programs were instituted that would translate into patient accessibility to the VAMC, and a dramatic increase in inpatient and outpatient loads.

(A) A veteran transportation network was established in cooperation with veterans service organizations to serve the veterans in the Miles City PSA. The system was established using busses and vans donated by the American Legion Yellowstone Post #4 and the VFW in Billings and the Montana DAV. Three of the four vehicles are operated exclusively by veteran volunteers.

(B) A veteran outreach program was initiated in concert with the American Legion of Montana for Native Americans, female veterans and Vietnam era veterans.

(C) "Veterans Awareness Programs" were sponsored by the American Legion of Montana and conducted throughout the entire state. The veteran public and their spouses were invited to attend an open forum and received information on veterans entitlement available to all eligible veterans and their dependents. The forums were conducted by VA Personnel, Montana State Veterans Affairs Personnel, and Service Officers of the American Legion. Subject information included compensation, non-service-connected pensions, VA insurance, VA home loans, burial benefits, VA hospitalization and nursing care, small business administration benefits, and social security benefits.

(D) Congressional Assistance:At the invitation of the American Legion of Montana, Senator Max Baucus and Congressman Ron Marlenee sponsored several visitations of congressional and VA administration officials to the Miles City VAMC including Congressman Gerald B. Solomon, Congressman Larry Coughlin, Senator George Mitchell, and on August 25, 1989, The Secretary for the Department of Veterans Affairs Edward J. Derwinski to study first-hand the problems that face rural health care of veterans in Montana. Each individual left with a much better understanding as to the importance of a VA hospital to care for rural Montana veterans.

The transportation network, veteran outreach programs, and the veterans awareness programs dramatically increased the patient and outpatient census at the VAMC. But our efforts to reach out and inform the veteran population of the quality

medical care available to them was to be curtailed. Due to the FY 89 system-wide shortfalls in the VA budget, the Miles City VAMC was forced to turn away nearly 800 veterans from the outpatient rolls and outpatient services were limited to Category A, Priority I veterans only. Since inpatient loads are largely dictated by outpatient activity, the inpatient census was decreased proportionately.

CONCLUSION:

The American Legion of Montana is proud to have had a direct part in the increased patient activity to Montana. The FY 89 budget restraints placed on the two VAMC's adversely affected many of those veterans who were added to the rolls during the expansion period. Other veterans who had been treated by the VA for a number of years were also turned away, including EX-POW's who suffered and endured torture and emotional trauma during their incarcerated period. All Category B and C veterans, and Category A veterans below Priority I were given thirty days medication and told to seek medical care in the private sector.

When these men and women were called on to serve their country in time of war, and to preserve the peace during the "cold war", there were no exceptions because of income or net worth. Likewise, "earned entitlements" that were "bought and paid for" through active military service in defense of our country should show no discrimination because of income or net worth.

Additionally, because a veteran is denied VA medical care due to a means test income criteria or net worth assets, does not always suggest they will be successful in obtaining alternate health care services.

In addition to access to care and transportation concerns, rural populations comprise the poorest segment of our society. Rural America has significantly higher uninsured populations (10 percent versus 14 percent for urban areas), poverty rates (16.3 percent versus 12.5 percent for urban areas), and more elderly people (25.4 percent

versus 12 percent of the total population). Within these overall figures for the civilian population, it is believed that many veterans are included. In 1989, 61 percent of the veterans treated at Miles City VAMC fall below the poverty level, while 92 percent earn less than $16,400 annually.

Veterans turned away from VA health care in rural areas may find it more difficult to obtain alternate services than veterans in urban areas. This is due to a lack of certain physician specialists in rural locations and to the distance involved in seeking general or subspecialty care. VA medical services are important to all veterans in rural areas because VA often concentrates testing equipment and experienced physicians in one location, whereas similar services in the private sector can be quite fragmented. For sick and elderly veterans, travelling large distances is no easy task.

Among some topics to consider in improving rural health care services are: enhance staff recruitment and retention by offering physicians and medical support personnel incentive bonuses to practice medicine in rural locations; budget considerations should be given to rural VA Medical Centers to allow for the establishment of a transportation network soliciting volunteer support from service organizations; make greater use of mobile health care systems; and establish a mechanism to internally appropriate funding necessary to support rural health care facilities.

In order for VA to identify the magnitude of current access to care problems encountered by the rural community, we support the continued study of this matter through a VA appointed task force. We believe VA health care capabilities in rural areas should receive equal priority to other Department programs.

Mr. Chairman, with Veteran's Day - 1989 just behind us by four days, perhaps we should reassess our acknowledgment of those who served to support the freedoms we all enjoy today, America's veterans. I would like to share with you and the members of the Committee, a dialogue to the American Veteran which was composed by Vern Miller, a member of The American Legion Yellowstone Post #4 of Billings, Montana. It is entitled "The American Veteran".

"THE AMERICAN VETERAN"

WHEN AMERICA WAS STRUGGLING TO HOLD ON TO ITS FLEDGLING LIFE - I WAS THERE.

MY FEET WERE FROSTBITTEN AT VALLEY FORGE. MANY OF MY COMRADES LEFT IN DESPAIR, BUT I TEDDY ROOSEVELT SAID, "FOLLOW ME, BOYS! AS WE CHARGED UP SAN JUAN HILL.

I WENT "OVER THERE" TO THE MUDDY, BLOODY TRENCHES OF FRANCE AND WHIPPED THE KAISER's BUTT.

I WAS THERE WHEN MIGHTY ARIZONA WENT DOWN IN PEARL HARBOR AND PART OF ME IS THERE EVEN NOW.

I HAVE BEEN TO PLACES YOU WOULDN'T BELIEVE! PLACES WITH NAMES THAT SOUNDED STRANGE TO YOU WHEN YOU FIRST HEARD THEM, AND THEN THEY BECAME FAMILIAR, SUCH PLACES AS A HELL-HOLE CALLED GUADACANAL, THE BLOODY BEACHES OF IWO JIMA, OMAHA BEACH, WAKE ISLAND, AND A PLACE CALLED BATAAN WHERE I WAS INVOLVED IN SOMETHING THAT BECAME KNOWN AS THE "BATAAN DEATH MARCH".

I HAVE HEARD THE EXPRESSION "YOURS IS NOT TO-WONDER WHY, YOURS IS BUT TO-DO-OR DIE." I OFTEN DID BOTH.

I WAS A TAIL GUNNER ON A B-17 OVER HITLER'S GERMANY. I SAW MANY OF MAY BUDDIES GO DOWN IN FLAMES OVER THE NORTH ATLANTIC.

I WAS THERE AT THE "FROZEN CHOSIN" IN KOREA, AND AT A PLACE THAT BECAME KNOWN AS "HEARTBREAK RIDGE".

I WAS THERE AT THE SEIGE OF KHE SANH, AND I BECAME PART OF THE MENU ON "HAMBURGER HILL".

I HAVE LOOKED OVER MY SHOULDER FROM LONELY BUS STATIONS, TRAIN DEPOTS, AIRPORTS, AND SEAPORTS AT WEEPING WIVES, PARENTS, BROTHERS, SISTERS AND YES - SWEETHEARTS, WHO WERE TRYING TO SAY GOODBYE TO ME GRACEFULLY, AND FAILING MISERABLY; MANY FOR THE LAST TIME.

I HAVE RETURNED HOME TO EVERYTHING FROM GREAT CELEBRATIONS AND ACCOLADES TO ANONYMITY AND DERISION. I HAVE BEEN CALLED EVERYTHING FROM A "HERO" TO A "BABY KILLER" - AND I'LL DO IT AGAIN IF IT BECOMES NECESSARY - WHY??

BECAUSE, WHEN THE FRAMERS OF THE CONSTITUTION SECURED FOR US THE BLESSINGS OF "LIFE, LIBERTY AND THE PURSUIT OF HAPPINESS", IT WAS NOT WITHOUT SACRIFICE; AND KEEPING THOSE BLESSING IS WORTH WHATEVER PRICE I MUST PAY. YES - THERE IS SOMETHING WORTH DYING FOR, AND I THANK GOD THAT I POSSESS SOMETHING THAT PRECIOUS.

I WANT THAT FOR YOU, MY FELLOW COUNTRYMAN.

I WANT IT FOR MY CHILDREN AND MY CHILDREN'S CHILDREN.

I ASK NO REWARDS OR PRAISE.

I ASK ONLY THAT REMEMBER THAT I WAS THERE WHEN YOU NEEDED ME, AND THAT YOU'LL BE THERE FOR ME NOW THAT I NEED YOU. - I AM.

THE AMERICAN VETERAN

In closing Mr. Chairman, may I repeat a phrase that was introduced by H. F. "Sparky" Gierke, Past National Commander of The American Legion, "PROUD TO BE A VETERAN, PROUD TO BE A MEMBER OF THE AMERICAN LEGION, AND ABOVE ALL, PROUD TO BE AN AMERICAN". Mr. Chairman that concludes my testimony.

Redding Medical Office: Progress and Projections

I. Introduction

The VA Medical Office in Redding, California opened in April 1988 as a direct result of a Senate Appropriations Committee mandate for a pilot demonstration to address the concern of provision of health care services to veterans in rural, remote areas. This report details the background, history, progress and future directions of the VA Medical Center (VAMC) Martinez efforts to provide health care services to the rural veteran population in Northern, California.

II. Overview of VAMC Martinez, California

The Martinez catchment area includes most of Northern California, beginning in the San Francisco Bay Area and extending north and east to the Oregon and Nevada borders. This area covers all or part of 24 counties. The major population centers within the catchment area are Alameda County, with 52,157 veterans; Contra Costa County with 84,970 veterans, Sacramento County, with 113,670 veterans and Solano County with 34,220 veterans. The rest of the veteran population resides in smaller, more rural areas.

VA operates a 402-bed tertiary medical center in Martinez to provide the majority of inpatient and outpatient care to the veteran patient population in the catchment area. Dedicated in 1963 as a moderate sized suburban hospital, VAMC Martinez has developed into a complex, full-service medical center. The range of programs offered at Martinez is extensive, including all specialties, except transplantation and open heart surgery. Among the programs offered are a women's program with a full-time gynecologist; a rapidly growing, aggressive neurosurgical program; and, the only radiation/oncology department in the Medical District. In addition, the medical center has outpatient clinics at Sacramento and Oakland, a Medical Office at Redding, a drug dependency treatment clinic at Berkeley and day hospitals in Martinez and Oakland. The Martinez VAMC is one of the most active medical centers in its medical district.

The veteran population presently served by the medical center and its satellite clinics is nearly 420,000, representing approximately 15 percent of the veteran population throughout the State of California. Since the conversion of the VAMC Livermore to an extended care facility, the vast majority of the veterans residing in that area (approximately 125,000) look to the Martinez VAMC for acute medical and surgical care as well as ambulatory care involving services beyond the basic primary ambulatory care level. Hence, the Martinez facility currently serves a geographical area approximately the same size as the State of Florida, and treats a veteran population which approaches 40 percent of the veteran population in Florida

(approximately 545,000 veterans versus approximately 1.3 million veterans). More veterans reside in the Martinez catchment area than in 26 of the 50 United States, including Colorado, Iowa, Oklahoma, and South Carolina (see attachment A).

III. Original Proposal for health care services in Redding

Redding serves as the geographical and commercial center of the northern half of the Martinez geographical catchment area. The Redding area comprises nine counties stretching over 25,000 square miles, and has a veteran population of approximately 68,000. The veterans residing in this area are representative of the veteran population throughout the state, and consist of WWI, WWII, Vietnam era and Korean conflict service men and women.

Veterans in the Redding area have long faced tremendous problems in terms of access to health care services. The nearest VA facility to Redding was the Sacramento Outpatient Clinic (OPC) (159 miles) and the closest inpatient facility was VAMC Martinez (220 miles). For many of the counties surrounding the Redding area, transportation to these facilities was, and is, limited to two lane highways and country roads that travel through narrow mountain passes and steep grades. There is virtually no public transportation in these areas. The high unemployment and low per capita income which characterize the Redding area further reinforce the barriers to access for veterans.

The need for a VA medical presence in the Northern California/Redding area was established by VA through the Medical District Initiated Program Planning (MEDIPP) process, Veterans Services Organizations and the Northern California Health Systems Agency, through a series of studies and task group reports that date back to 1980. Given the large veteran population in the Redding area, the need existed for a full service clinic. This is supported by the fact that VA currently has 20 medical centers that serve smaller veteran populations than reside in the Northern California/Redding area, including Grand Junction, Boise, Poplar Bluff, and Fort Harrison (attachment D). To comply with the Senate Appropriations Committee mandate for a pilot demonstration, the Martinez VAMC submitted a proposal to develop a primary care Medical Office in Redding, California, (attachment E). The Redding Medical Office was funded as a result of the proposal and opened in April, 1988.

IV. The Redding Medical Office Experience

A. Services

The Redding Medical Office provides primary medical care for its veteran population. The Office is designed to resemble a private group practice in general medicine and operates with routine hours Monday through Saturday. Clinics are offered on-site in the following areas: General Medicine, Hypertension, Diabetes, Surgery, Social Work, Alcohol Treatment, Women's Health, Psychology and Smoking Cessation. Ancillary services to support these clinics are provided by a mixture of VA and non-VA sources. At present, Pharmacy services are divided into a Sacramento and a Redding component. A local contract pharmacy in Redding fills all emergency and urgent prescriptions for up to five days after the patient is seen at the clinic.

During this five-day period, the full prescription is filled at the Sacramento OPC and then sent to the patient by mail. Radiological services are provided by a private physician who shares the building in which the Redding Medical Office is located. Staff at the Sacramento OPC read the X-ray films that are taken by the contracting physician. Laboratory specimens are collected at Redding by a phlebotomist/technologist and all but the most routine tests are sent out to a local reference lab. Optometry services are not available to patients at the Redding Medical Office.

Veterans who are initially seen in the Medical Office in Redding, and who require subspecialty care, are referred to subspecialty clinics at VAMC Martinez, the Sacramento OPC, and in emergency situations, to private practitioners. A van donated by the California Women's Bowlers League and driven by volunteers transport approximately ten persons per day to VAMC Martinez for inpatient and outpatient care. The major subspecialties utilized by Redding patients in FY 1988 and FY 1989 (FYTD through May) are as follows:

Subspecialty	Clinic Counts
Orthopedics	318
Ophthalmology	246
Cardiology	236
Ear, Nose and Throat	163
General Surgery	148
Neurology	141
Psychiatry	118
Urology	105

B. Workload

The original workload projections for the Redding Medical Office estimated approximately 15,000 annual outpatient visits in FY 1989 and 20,900 visits in FY-2000. These estimates have proven to be low, based on documented workload. During the calendar year May 1988 to May 1989, the Redding Medical Office conducted 19,254 patient visits. Unofficial projections, submitted in the FY 1989 MEDIPP plan, call for 34,000 visits in FY 2000. These projections are based on several factors including, 1) actual demand experienced during the first year of operation of the Medical Office; 2) demographic projections in the Redding area, which call for a 140 percent increase in population 60 years of age and older between 1985 and the year 2000; and 3) MEDIPP plans to establish a mental health team at the Medical Office.

Between the period of April 1988 and January 1989, the Medical Office routinely treated patients of category B and C classification. At times, category B and C patients comprised 17.5 percent of the total patient visits for a given month. To reduce the level of discretionary workload, a policy was enacted in February, 1989 which significantly lowered the percent of B and C patients in the ensuing months. As of July, 1989, B and C patients comprised only 4.8 percent of the month's total visits. Nevertheless, there has been no reduction in the overall demand for services at the Medical Office (see attachments F, G, and H). The following shows workload data for September, 1988 and April, May, June, and July 1989:

Month	Patient Visits	Cat. A	Cat. B	Cat. C	Percent of Cat. B & C Patient Visits
Sept 88	1,475	1,116	88	110	13.4
Apr 89	1,577	1,439	48	69	7.4
May 89	1,815	1,657	48	74	6.7
Jun 89	1,859	1,723	61	56	6.3
Jul 89	1,376	1,293	36	30	4.8

VA outpatient utilization rate for the 68,000 veterans in the Redding area is currently 415 visits per 1,000 veterans. This figure is higher than the utilization rates prior to the opening of the Medical Office, but, nevertheless, remains significantly below national average utilization rates. This shows that there is still a great need for the provision of health care services in this area.

VA Outpatient Utilization Rates
Per 1,000 Veteran Population - U.S. and Redding

	Visit Rate/1,000 Vet. Pop.
Shasta County (before Redding OPC, FY 1987)	236
Redding PSA (5/88-5/89)	415
Reno PSA	1,045
Fresno PSA	878
U.S.	796

C. Staff

The Redding Medical Office was originally designed to have four physicians, a part-time optometrist, two nurse practitioners, and two pharmacists along with the necessary support staff. During the early months of operation, it became clear that in our efforts to demonstrate a model by which we could provide cost-effective care, we did not include sufficient support staff for the clinic. Our staffing numbers were insufficient to meet the work demand, and the staff was not capable of effectively handling the administrative workload generated by the high volume of patients. As a result, we added five Medical Administrative Service FTEE: a file clerk, a reciptionist, a medical transcriptionist, and two program clerks.

In addition, the Pharmacy Service has suffered from inadequate staffing. The Redding Medical Office is currently generating 64,000 prescriptions per year which, based on VA criteria, demands three FTEE. The original proposal for the Redding Medical Office called for two pharmacists and funding on a recurring basis was provided for one position. The Martinez VAMC has absorbed the cost for employing a second pharmacist. Recently, the Director, Western Region provided the funding for this second pharmacist position, and for one FTEE pharmacy technician for FY 1990. Pharmacy will now be staffed at a level commensurate with VA criteria. The following provides a comparison of staffing at the Redding Medical Office as originally proposed and as in effect during FY 1989:

STAFFING

	Proposed	Current
Physicians	4	3 (2 part time/2 full time)
Nurse Practitioner	2	2 (1 position vacant)

	Proposed	Current
Licensed Vocational Nurse	2	1
Social Worker	1	1
Psychologist/mental health	1	1
Pharmacist	2	2
Lab Technicians	1	1
Health Technician	0	4
MAS Staff	4	9 (2 temporary)
Optometrist	.5	0
Total Staff	17.5	24

Since its opening in April, 1989, the Redding Medical Office has been extremely successful in bringing efficient and high quality health care services to a previously underserved population. The Medical Office is currently treating more patients than originally projected and is enjoying widespread community support.

ATTACHMENT A

VETERANS BY STATE (in thousands - 1984 figures)

STATE	VET. POP.	STATE	VET. POP.
Alaska	54.5	Nevada	129.4
Colorado	403.7	New Hamp.	133.6
Delaware	77.8	New Mexico	159.8
Dist. of Col.	71.9	N. Dakota.	72.4
Hawaii	102.9	Oklahoma	396.4
Idaho	120.4	Oregon	389.0
Iowa	356.3	Rhode Island	128.8
Kansas	304.7	S. Carolina	353.7
Kentucky	405.6	S. Dakota	87.0
Maine	153.6	Utah	152.3
Mississippi	245.8	Vermont	63.2
Montana	107.9	W. Virginia	242.5
Nebraska	191.8	Wyoming	63.5

ATTACHMENT B

COMPARATIVE ANALYSIS OF CALIFORNIA VA MEDICAL CENTERS

VAMC	Veteran Population	PerDiem Cost	Patients Treated excluding one day dialysis	Outpatient visits	Square feet (1000s)	1989 Preliminary RAM Allocation (dollars)
Fresno	131,367	342	5,095	92,592	386	19,679,534
Livermore	81,241	330	1,571	32,738	273	12,695,342
Loma Linda	340,250	297	8,469	175,685	727	36,303,929
Long Beach	340,250	310	16,050	352,298	1,368	67,496,608
Martinez	417,242	279	8,717	243,646	422	36,644,881
Palo Alto	305,368	279	10,658	237,014	2,038	59,262,037
San Diego	363,000	385	10,027	230,016	856	45,655,132
San Francisco	246,006	369	8,220	145,809	874	35,329,082
Sepulveda	340,250	349	7,196	231,307	1,341	41,749,410
W. Los Angeles	340,250	329	14,626	317,032	2,806	79,070,394
Total	2,905,224		90,629	2,058,137	11,091	433,886,349

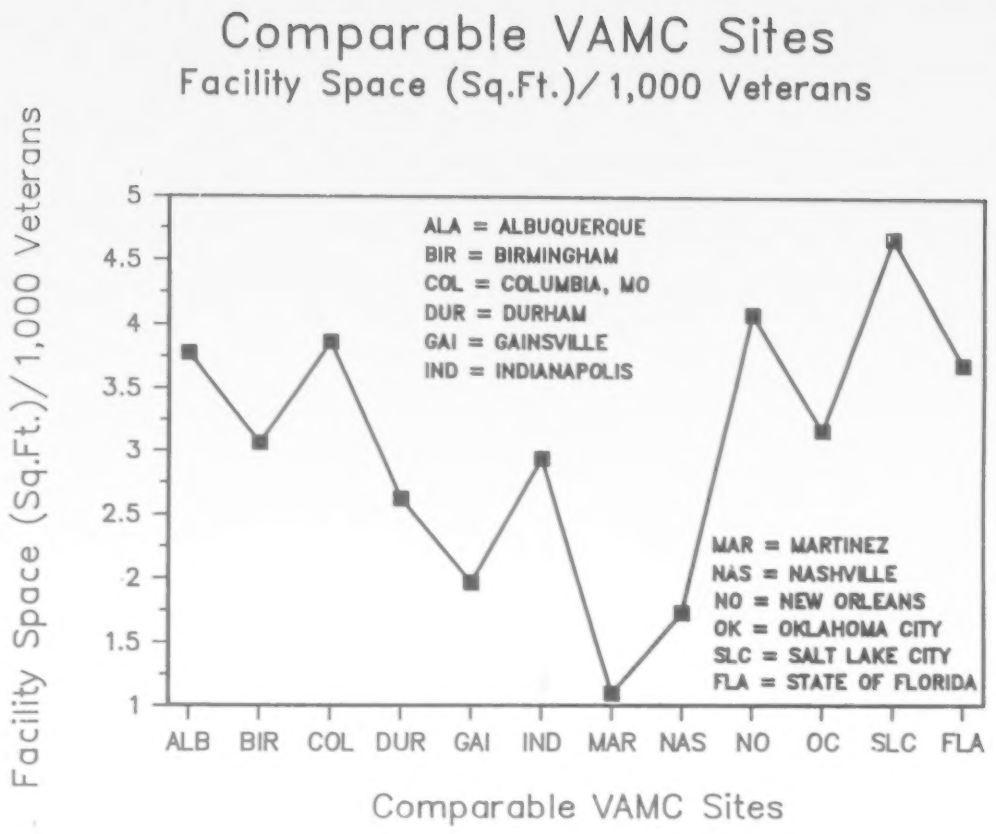
This comparative data for all ten California VA Medical Centers shows VAMC Martinez ranks first in number of veterans in its catchment area, has the lowest per diem cost, third highest number of ambulatory visits (FY'87), and the fifth highest number of inpatients treated.

VAMC Martinez has:

14.3% of California veterans

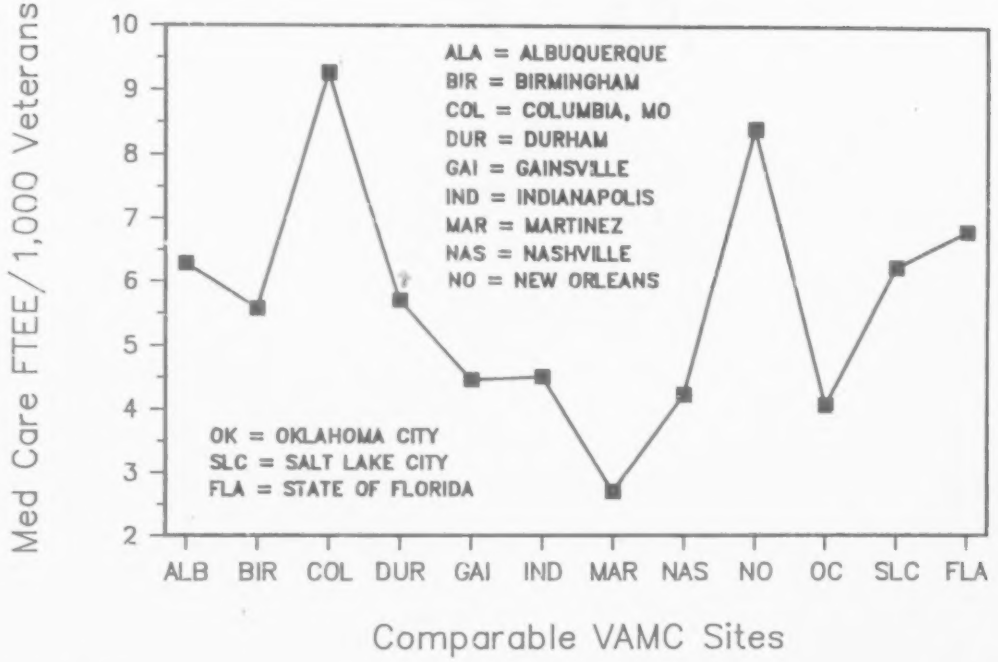
8.4% of Medical Center resources

3.8% of space of California hospitals

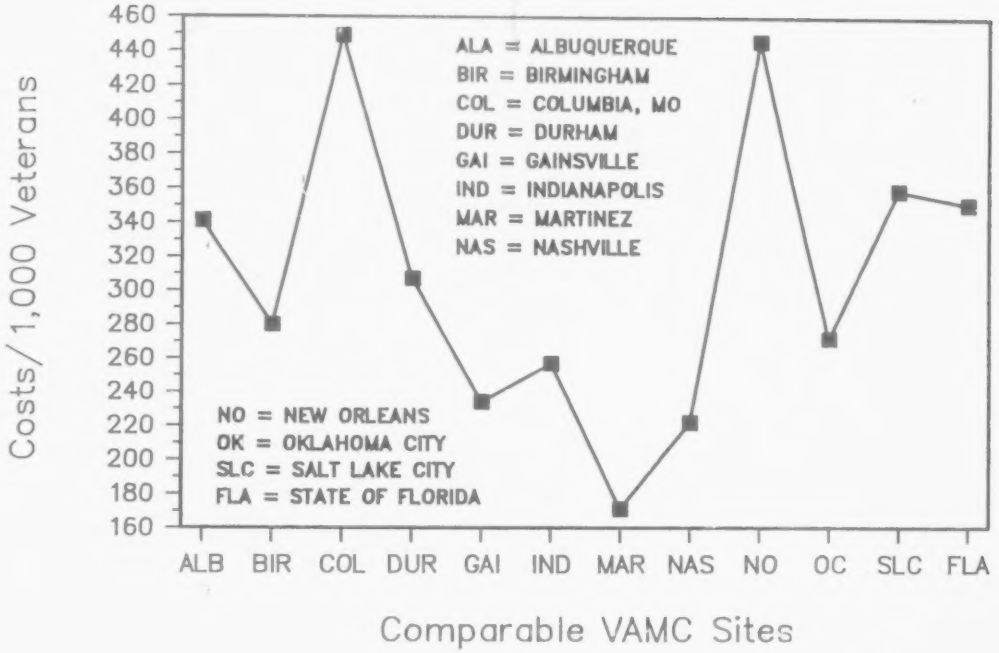

Comparable VAMC Sites
Facility Space (Sq.Ft.)/ 1,000 Veterans
Facility Space (Sq.Ft.)/ 1,000 Veterans
5
4.5
4
3.5
3
2.5
2
1.5
1
ALA = ALBUQUERQUE
BIR = BIRMINGHAM
COL = COLUMBIA, MO
DUR = DURHAM
GAI = GAINSVILLE
IND = INDIANAPOLIS
MAR = MARTINEZ
NAS = NASHVILLE
NO = NEW ORLEANS
OK = OKLAHOMA CITY
SLC = SALT LAKE CITY
FLA = STATE OF FLORIDA
ALB BIR COL DUR GAI IND MAR NAS NO OC SLC FLA
Comparable VAMC Sites

Comparable VAMC Sites

Med Care FTEE/1,000 Veterans

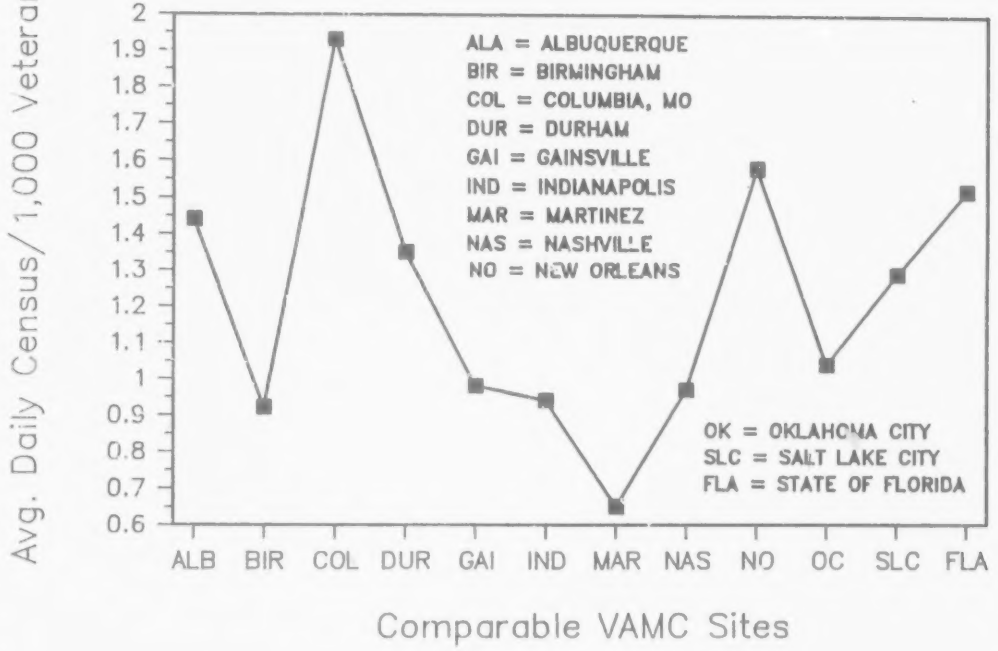


Comparable VAMC Sites
Costs/1,000 Veterans



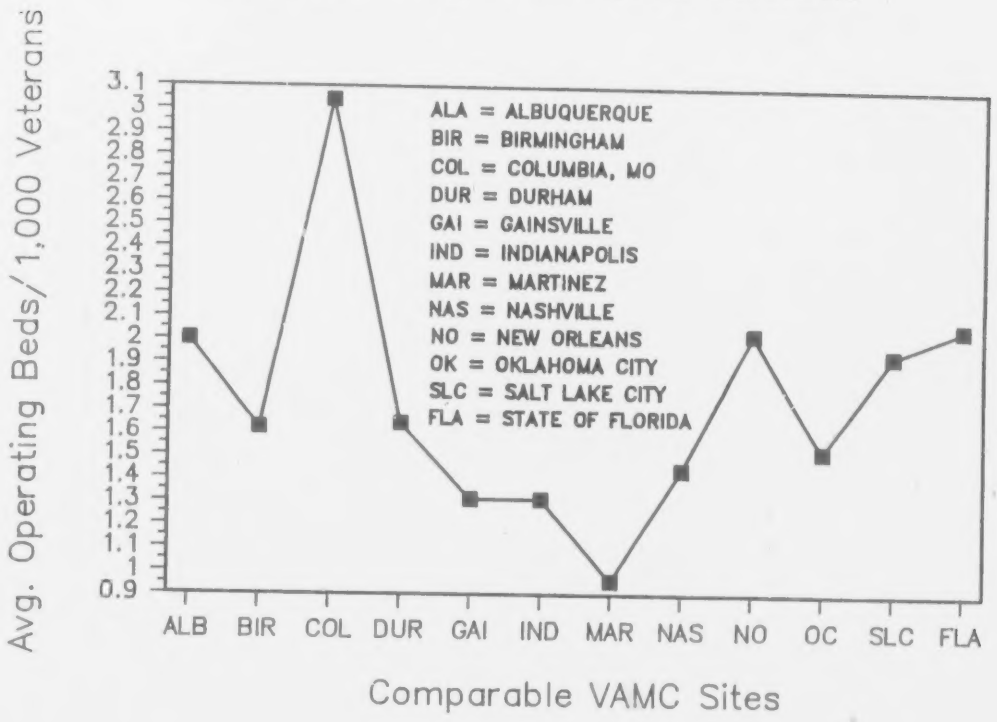
Comparable VAMC Sites

Avg. Daily Census/1,000 Veterans



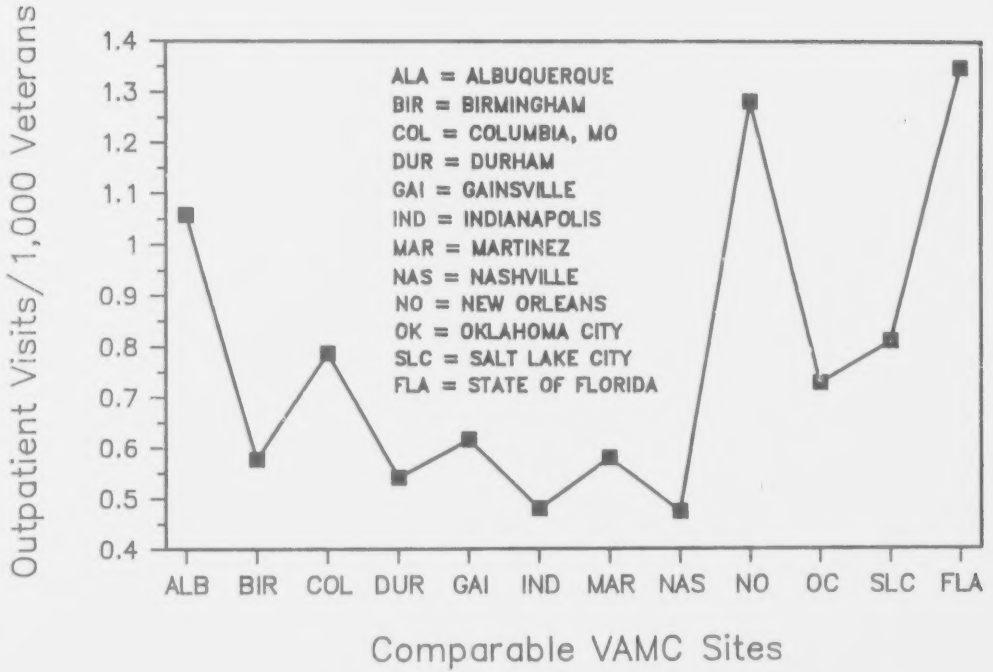
Comparable VAMC Sites

Avg. Operating Beds/ 1,000 Veterans



Comparable VAMC Sites

Outpatients Visits/ 1,000 Veterans



ATTACHMENT D

VETPOP BY PSA FOR 1990

PARENT STATION	PRIMARY SERVICE AREA	VETPOP ALL-AGES
KERRVILLE	KERRVILLE	16,666
BONHAM	BONHAM	24,939
BATH	BATH	28,772
FORT MEADE	HOT SPRINGS	31,541
HOT SPRINGs	HOT SPRINGS	31,541
GRAND JUNCTION	GRAND JUNCTION	34,824
MILES CITY	MILES CITY	36,780
SHERIDAN	MILES CITY	36,780
CHEYENNE	CHEYENNE	38,602
GRAND ISLAND	GRAND ISLAND	42,471
LINCOLN	LINCOLN	42,747
PRESCOTT	PRESCOTT	44,103
BECKLEY	BECKLEY	44,294
LEAVENWORTH	LEAVENWORTH	45,876
TUSKEGEE	TUSKEGEE	49,183
TOPEKA	TOPEKA	54,693
POPLAR BLUFF	POPLAR BLUFF	57,568
WALLA WALLA	WALLA WALLA	59,862
IRON MOUNTAIN	IRON MOUNTAIN	63,075
BOISE	BOISE	66,119

ATTACHMENT E

ALTERNATIVE PROPOSAL FOR PROVIDING HEALTH CARE TO VETERANS IN RURAL REMOTE AREAS

VA MEDICAL OFFICE
REDDING, CA.

Submitted by:
VAMC, MARTINEZ
C. H. Nixon
Director

EXECUTIVE SUMMARY

The Martinez catchment area includes most of Northern California with the exception of the western most coastal counties. It begins at the San Francisco Bay Area and extends north and east to the Oregon and Nevada borders. The eastern most counties bordering Nevada utilize both Reno and Martinez. The veterans from these counties generally look to Reno for primary and some secondary care with referral to Martinez. In the winter months, since they are on the eastern side of the Sierra divide, they receive their health care almost exclusively from Reno. The Martinez catchment area contains approximately 500,000 veterans. Since the conversion of the VA Medical Center Livermore to an extended care facility, the vast majority of the veterans residing in that area, approximately 125,000, look to the Martinez VA Medical Center for acute medical and surgical care as well as ambulatory care involving services beyond the basic primary ambulatory care level. Hence, the Martinez facility serves a geographical area approximately the same size as the State of Florida with a veteran population, approximately 50 percent of the State of Florida (approximately 625,000 veterans versus approximately 1.3 million veterans).

Redding, California, serves as the geographical and commercial center of the northern half of this geographical catchment area which has a population of approximately 68,000 veterans. The distance from Redding to the Bay Area is over 200 miles. The distance from Redding north to the California border is over 100 miles. The distance from Redding to the northwest (Crescent City) area is approximately an additional 200 miles. The number of veterans and the distances involved provide an overwhelming justification for the congressionally mandated pilot study unequalled anywhere in the Continental United States with the possible exception of Alaska.

This tremendous need will provide a demand far beyond the capacity of a store front operation, traveling team, or other limited or circumscribed alternatives. We have explored many options but in the final analysis we discarded all suggestions and options that did not provide for an established community based medical presence capable of providing the full range of primary ambulatory care of the type that would be provided by an adult family practice.

An innovative model has been developed which we feel is reasonably consistent with the anticipated demand of the veteran population of this area (68,000). It will be cost effective under the resource allocation methodology with a total start up cost that is justifiable and can be supported by a meticulous review of concerned VA Central Office staff. Our proposed alternative is modeled after a group medical practice with four primary care providers, an appropriate but minimal office support staff, and provision for laboratory, radiology, and pharmacy support services utilizing combinations of contract community services, internal office support, and supplemental services from the Sacramento Outpatient Clinic or the Martinez Medical Center as appropriate and as permitted by available commercial courier services. When this proposal has been reviewed and approved and funded by Central Office, market surveys and negotiations will begin for the most advantageous location and the best combination of the most cost-effective alternative support arrangements.

It is anticipated that the proposed alternative which we are referring to as the VA Medical Office in Redding will be capable of meeting a demand of 15,000 to 25,000 visits per year. The Medical Office will be structured to encourage the greatest use of people, equipment and facilities to provide primary care in the most cost effective way possible consistent with quality services. The organizational and program structure will provide for incremental expansion as appropriate depending upon the evaluation of the demonstration project. Our initial budget proposal provides for 15,000 visits and is consistent with the reimbursement provided by the RAM methodology. The break even point is approximately 16,000 visits. The projected average cost per outpatient visit is substantially below the VA national experience and is consistent with the cost of an ambulatory care visit at Oakland, Sacramento and Martinez, the other major components of the VA health care program for Northern California.

Apart from the distance and time factors involved with traveling to Redding to begin negotiations for our site, back-up support, etc., we have chosen not to meet with the general public and broad provider community because of the history of intense interest in having a VA presence in the Redding community followed by delay, disillusionment and anger. However, contact has been made with the County Board of Supervisors, the Mayor's Office, the President of the County Medical Society, the Medical Director of Shasta General Hospital, and the Director of the UC Davis Family Practice Residency program based at the Shasta General Hospital. In all instances they have expressed strong support and a continuation of their past interest in a VA medical presence in Redding and have reaffirmed their willingness to work with and assist the Veterans Administration in developing a viable Redding based outpatient program. The ground work has been layed and agreement has been reached in concept for designees from these organizations to serve as a community based advisory committee once approval is given to proceed. We have also made limited contact with interested veterans organizations but only at the state level.

There is strong, pervasive, broadly based community support for the Medical Office extending throughout the community including the private sector providers. We are prepared to give the proposed Redding Medical Office top priority and the personal support and involvement of the management triad. When approval to proceed is given we are ready to move forward with all due haste in establishing this very badly needed service in the Redding area and look forward to having it fully operational before the end of 1987. If additional information is required please contact the Hospital Director or Mr. Pat Sullivan at FTS 450-0201.

ALTERNATIVE FOR PROVIDING HEALTH CARE TO VETERANS IN RURAL REMOTE AREAS

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I. INTRODUCTION

The Senate Appropriations Committee has directed the Veterans Administration to conduct two pilot demonstrations for providing health care to veterans in rural remote areas. The two areas chosen for the pilot demonstrations are Northern New Mexico (Farmington/Four Corners area) and Northern California (Redding/Humboldt County area). These two areas offer two diverse settings for examining alternative modes for providing health care service to veterans in remote rural areas. The Northern New Mexico area (veteran population approximately 35,000) has a low population density and is geographically disperse while the Northern California area (veteran population approximately 68,000) has high population density with a geographically central location in Redding California. This report sets forth a proposal for the best alternative for providing health care to veterans in the Northern California area. The sponsoring VA Medical Center for this pilot program will be VAMC Martinez, California.

II. BACKGROUND

A. Primary Service Area

This proposal addresses a nine county area in Northern California that is medically underserved by the Veterans Administration. The need for a VA medical presence in the Northern California/Redding area has been previously established by the VA through the MEDIPP process, veteran Service Organizations and the Northern California Health Systems Agency through a series of studies and task group reports that date back to 1980. This rural remote area covers 25,000 square miles and has a veteran population of all ages of approximately 68,000 veterans (See map of proposed service area, Attachment A). These nine counties are Butte, Del Norte, Glenn, Humboldt, Plumas, (Western half) Shasta, Siskiyou, Tehama and Trinity; the geographic center of this area is in Shasta County with the population center of Shasta county being Redding, California (population 42,000). The veteran population of this area would be representative of the veteran population of the rest of the state having some WWI, Vietnam Era and Korean Conflict veterans with the majority (52 percent between ages 49 and 74) being WWII Era veterans.

B. Special Access Problems

1. Distance, Travel Time - The distances to current VA facilities creates a significant barrier to veterans in Northern California in need of medical treatment. Located in VA Medical District 26, the closest VA facility to Redding is the VA Outpatient Clinic in Sacramento, California (159 miles) and the closest inpatient facility is VAMC Martinez, California (220 miles). Distances from most communities in the area to a VA hospital are between 200 and 300 miles representing a four to six-hour drive. The surrounding counties are sparcely populated with limited health care and social services, high unemployment, and per capita income that compounds rather than compensates for the distance and long travel time.

2. Transportation, Roads - Interstate highway connects Redding with the rest of California and although the city of Redding is served by Amtrak and Greyhound bus service, public transportation travel to VAMC Martinez is costly and requires having overnight accommodations. For the

2.

remainder of the Northern California area, particularly the surrounding counties, transportation is limited to two lane highways and country roads that travel through narrow mountain passes and steep grades with virtually no public transportation system. Winter travel is always difficult and at times impossible without snow chains or a 4-wheel drive vehicle.

3. Cultural, Language - Cultural or language barriers do not generally compound access problems. There is a significant but not large Native American population.

4. Geographical, Weather - Redding is situated at the end of a horseshoe shaped valley and is surrounded on the West, North and East by high mountains. Travel problems are worsened by heavy winter rain, fog and snow in the higher elevations and health problems of the older veteran are complicated by the harsh winters.

5. Other - Inadequate financial resources prevent many rural veterans from obtaining care from non-VA sources . In addition, high unemployment in the lumber industry and its effect on the economy has resulted in the loss of access to health care for many veterans. The counties surrounding Redding have a low tax base, limited health care and modest social services.

C. What VA Programs are Available and Being Used? Include contracting for services, sharing agreements, community-based clinics, outreach programs and other VA programs.

Currently there are no VA Medical programs located in the Redding/Northern California area. Patients must travel several hours to a VA Medical Center or outpatient clinic for treatment. Qualified service-connected veterans, however, may take advantage of the fee basis program which provides for medical care to veterans who do not have access to a VA facility. For FY 86, this program provided fee basis services to approximately 1,500 Northern California veterans at a cost of about $500,000. In addition, there are Vietnam Veterans Outreach centers in Northern California in Weaverville and Eureka and an outreach contract-for-fee provider in Redding all of whom provide psychological and counseling services to Vietnam era veterans. Community nursing homes and alcohol treatment halfway houses provide services to a small group of eligible veterans through VA contracts administered by VAMC Martinez. A VA field social worker provides limited follow-up services.

D. What Health Care Services are Needed to Improve Access?

1. Primary, Secondary, Tertiary, Long Term Care Services - The greatest need for medical care for veterans in the Northern California/Redding area is for primary medical care and outpatient drug and alcohol treatment. Secondary care pertinent to the health needs of the population, e.g.: pulmonary, cardiology, hypertension, etc., would also be required. Other secondary and tertiary care can be provided through the fee basis program for eligible service connected veterans and for nonfee eligible veterans by referral to the Sacramento Outpatient Clinic and VAMC Martinez. The Sacramento OPC is a full-service outpatient

3.

clinic offering a full range of internal medicine and medical subspecialties and ambulatory care in most subspecialties of surgery. VAMC Martinez is a 402-bed acute medical, surgical and psychiatric medical center affiliated with the University of California at Davis. Inpatient and outpatient services are offered in all major medical and surgical subspecialties. Programs unique to Martinez VAMC also include full service care to female veterans and a radiation therapy program for oncology patients. Nonacute long term care is addressed through contract nursing home care. Contract arrangements for emergency hospitalization will be necessary for patients who cannot be safely transported to VAMC Martinez.

2. Ancillary Services such as Pharmacy, Laboratory, X-ray - Pharmacy, laboratory and x-ray services would be required to support primary care. Most of these services would be provided by Sacramento OPC and/or Martinez VAMC with effective contract courier service. The remainder are available in the community under contract or through sharing agreements.

3. Medical, Surgical, Psychiatric - The greatest demand for services would be primary medical care and alcohol and drug counseling with limited ambulatory surgical and secondary care. Psychiatric care, although desirable, is less of an acute problem and would be addressed through the fee basis program and programs at the Sacramento OPC and Martinez VAMC and will be further assessed after a VA medical presence is established.

E. Alternatives for Health Care Delivery

Alternative health care delivery systems currently being used in rural/remote areas across the country include:

Contracting for Services
Fee-basis care
Sharing agreements
Community-based clinics
Mobile staff arrangements
Transporting patients to services
Utilization of telecommunications
Combinations of two or more alternatives

The two major considerations in evaluating alternatives for providing cost effective quality patient health care in the Redding area are the excessive distances involved and the high demand for services, i.e.: large numbers of veterans with limited access to VA and non-VA health care. In considering alternative delivery systems those programs which required the regular movement of staff or patients to or from the Northern California area were ruled out due to the long distances, hazardous roads and harsh winters in many of the areas served as well as the inefficiency of physicians and other health care providers spending long hours driving. The round trip driving distance from Redding to Sacramento VAOPC is five hours. Driving time is seven to eight hours from the most distant counties. Further consideration of other alternatives to address the large numbers of veterans and high demand for services in the Northern California/Redding area, suggest a combination of the remaining alternatives would best meet the health care needs in the most cost effective way. This combination of

4.

alternatives, a new model, is similar in concept to a community based clinic, but more closely resembles a physician's office practice and will be referred to as a VA Medical Office. The remainder of this proposal outlines the demand for services and anticipated workload, a description of the VA Medical Office and the estimated costs, resource allocation methodology reimbursement and funding requirements for this program.

F. Demand for Services

The following table outlines the projected 1988 veteran populations of the 8 1/2 Northern California counties to be served, the estimated demand or visit rate per veteran and the 1988 visit estimate utilizing the approved 1984 Outpatient Clinic Sizing Methodology:

County	1988 Vet Pop	Visit Rate Per Veteran	1988 Visit Estimate
Butte	18,776	.170	3,191
Del Norte	2,134	.118	251
Glenn	2,210	.170	375
Humboldt	12,252	.118	1,445
Plumas (Western half)	1,319	.118	155
Shasta	15,339	.435	6,672
Siskiyou	5,160	.190	997
Tehama	5,251	.190	997
Trinity	1,717	.170	291
Total	64,158		13,908

G. Estimated Workload

The needs assessment methodology demonstrates FY 88 estimated visits at approximately 14,000 per year. Based on VAMC Martinez's experience in treating veterans at two satellite outpatient clinics, in Oakland and Sacramento, and in the Martinez outpatient program (total FY 86 outpatient visits of 216,000) as well as the demographic and socioeconomic profile of the area, 15,000 visits per year is a minimum workload estimate for the Redding area. The model outlined in this proposal will address an estimated workload of 15,000 visits per year and offer cost reimbursement figures for a range of 10,000 to 20,000 visits per year. We believe the utilization rate in the VA approved methodology will be exceeded by a significant margin resulting in a demand approaching and perhaps exceeding 25,000 visits per year.

III. THE VA MEDICAL OFFICE IN REDDING

A. Description

The office will consist of four internists practicing in a clinical setting designed to resemble a private group practice having routine office hours five days per week from 8 A.M. to 5 P.M. Monday through Friday and 9 A.M. to 1 P.M. on Saturday. The office will be located in professional offices adjacent to or in one of the local community hospitals.

5.

B. Office Structure and Staffing

The medical office will be structured in a manner to encourage the greatest use of equipment and facilities at the least cost without resorting to broad scale contracts or total dependency on community diagnostic facilities. In addition to four physicians, staffing would include two RNs, two LVNs, one Social Worker, one Alcohol Dependency Treatment Counselor, one pharmacist, one phlebotomist/laboratory technician and four Medical Administration Service personnel. In keeping with the office practice design of the model, it is anticipated that the majority of routine consultations would be met by internal discussions between members of the staff, telephone conversations with consultant colleagues at the Martinez VAMC or Sacramento OPC and use of consultants from the community. Those patients requiring routine subspecialty referral would be scheduled to see appropriate professionals at the Martinez VAMC or the Sacramento OPC. Emergency consultations would be obtained within the local community.

C. Family Practice Residency Component

Currently the Family Practice Residency Program from the University of California Medical School at Davis (the VAMC Martinez's medical school affiliate) has a training program with eight residents in the Redding area. Dr. Perry Pugno, M.D., Director of the residency program has expressed enthusiasm and support for the possibility of resident participation at the VA Medical Office in Redding. Resident care will increase the capacity of the office in terms of numbers of patient visits. Teaching will occur in a highly structured and supervised environment conducive to the development and refinement of good office internal medicine practices. Residents in the later stages of training have had extensive experience in performing office minor surgical procedures and under the supervision of faculty from the Redding community will add this dimension to the otherwise internal medicine nature of the clinic. A teaching mission will increase the positive interactions between the office and the community and help to recruit office staff and maintain their clinical competency.

D. Ancillary Services

The office practice will be made as self-contained and efficient as possible. The objectives of self-reliance and efficiency, cost-effectiveness and quality of patient care were the major considerations in evaluating alternatives for ancillary services. Program chiefs and other subject matter experts were called on to develop a range of options for necessary support services. These options included medical center and Sacramento Clinic support, local contracting, fee basis, in-house provided and combinations of the above. The following recommendations represent the best of the available options and meet the objectives of the VA Medical Office model.

1. Laboratory Services - Laboratory specimens will be collected at the Redding clinic by a phlebotomist/technician and all but the most routine tests would be sent to the Sacramento OPC Laboratory or the Martinez VAMC Laboratory. This will require a minimal amount of equipment, i.e.: a centrifuge and refrigerator and specimens will be transported between Redding and the Sacramento Clinic or VAMC Martinez by reliable daily courier service.

6.

The projected increase in testing will require an additional FTE Laboratory technician at the Sacramento Clinic or VAMC Martinez Laboratory with additional materials and supplies to support this testing. Urgent or emergent tests will be performed in the community under a contract or sharing agreement.

2. Radiology Service - A portable x-ray machine will be installed in the office. Both the RNs and the LVNs will hold limited licenses from the State of California for the performance of diagnostic imaging. California law allows such an individual to be qualified in a maximum of two performance areas. All individuals could be licensed to perform chest radiology and long bones and joints. This arrangement would provide an essential service (chest radiology and long bones and joints) at all times and skull and/or abdominal x-rays could be added when the office is fully staffed. The physicians can review their own films and consult by telephone with the Radiologists at Martinez VAMC regarding unusual findings. All films will be sent to be read by a Radiologist at Martinez VAMC or Sacramento OPC on a daily basis. Only rarely will an office M.D. be required to seek a professional reading from a local Radiologist. This arrangement minimizes radiologic costs and maximizes physician independence.

3. Pharmacy Service - Two part-time Pharmacists (1.0 FTE total) will be assigned to the Redding office. Scheduling will be arranged to allow maximum usage of the Pharmacists with cross coverage for annual leave and sick leave and the presence of both Pharmacists during peak hours. The remaining Pharmacy workload will be addressed with the addition of a pharmacy technician at the Sacramento OPC to fill prescriptions which are sent to the patient by mail.

4. EKG Service - Routine EKGs will be obtained and interpreted in the office by the office staff and further reviewed by a cardiologist when appropriate.

5. VA/DOD Sharing - Beale Air Force Base hospital is approximately equidistant between Redding and the Sacramento VA Outpatient Clinic. The commanding officer of the hospital has been contacted and is supportive of exploring VA/DOD sharing between the proposed Redding Medical Office, the VA Outpatient Clinic in Sacramento, VAMC Martinez and the Beale Air Force Base hospital. A lack of time has not allowed for more than preliminary discussions, but VA/DOD sharing with Beale Air Force Base hospital will be pursued as a means of providing support to the Medical Office for ancillary and other services.

E. Providing for Services not Available at the Medical Office

Veterans who are initially seen in the medical office in Redding, and who require subspecialty care (including surgery) will be referred to subspecialty clinics at the Sacramento OPC or the Martinez VA Medical Center. Subspecialty follow-up care will be provided at the Redding office following episodes of hospitalization at the medical center in cooperation and consultation with the patient's inpatient physician.

7.

F. Space and Equipment

This medical office will require approximately 4,000 net square feet located in a local hospital or a professional office building with adjacent parking. Essential space requirements would include eight examination rooms with sinks, six personal offices for use by the physicians, eligibility/benefit counselor, transcription, alcohol counselor and social worker, treatment/medication room, specimen collection and processing area, reception area and waiting space, MAS service room for storage of records, a small pharmacy, and general storage and utility rooms. An initial equipment and furniture list in the amount of approximately $140,000 has been prepared and contains all of the necessary furniture and equipment to open the medical office in Redding.

G. Qualifications, Licensing and Privileges

Placing physicians at such a distance from the nearest VA facility involves some unique considerations. All physicians will be board eligible or board certified in internal medicine; subspecialty training in cardiology, pulmonary, endocrinology, rheumatology or infectious diseases would be sought, but will not be required. All physicians regardless of subspecialty training will be expected to perform in the role of practicing internist as their primary responsibility. Preference will be given to individuals who express a strong desire to perform as a team member, and treat all of their patients with the respect and concern they would afford patients in their personal office practice. All applicants will be expected to be licensed in the State of California. This requirement deviates from usual VA practice, and is necessitated by the somewhat isolated nature of the clinic, the need to be able to write prescriptions which can be filled locally and the requirement that patients be examined, treated and at times admitted to one of the local hospitals. Admitting privileges at a near by hospital will provide the opportunity for continuity of care, direct VA Control of contract hospitalization, complete the private practice paradigm, provide care by physicians whose performance standards are set and reviewed by the VA, and afford the opportunity to promote professional integration of the local VA physicians with their counterparts in the community. Active membership in the local county medical society will be required. This last point is intended to strengthen professional interactions and prevent the Redding based VA physicians from being viewed differently from their private practice peers. Credentials review and performance evaluation will be the responsibility of the ACOS/Ambulatory Care at the Martinez VAMC.

H. Supervision and Evaluation

Supervision will be multi-tiered. The designated Chief Medical Officer will be responsible for the daily function of the clinic and will supervise the function of the medical team directly and share responsibility with the administrative office manager for non-clinical personnel supervision. The radiologic function of the nurses with limited radiologic licenses will be reviewed periodically by the full time supervisor at the MVAMC. Persons within the office will communicate special concern to the designated CMO who will exercise discretion in terms of what persons are to be contacted, if any at the Martinez VAMC. Evaluation is a continuation of supervision.

8.

The ACOS for Ambulatory Care at Martinez VAMC or his designee will make periodic trips to Redding for purposes of reviewing overall progress, appropriateness of medical care, laboratory tests, x-rays, consultations and the organization and function of the clinic as a whole. Computerized clinic profiles will be developed and records of amounts and costs of prescriptions, tests and x-rays will be compared to those available for physicians practicing at the Sacramento, Oakland and Martinez VAMC Ambulatory Care Clinics. Trips to the medical office by the ACOS for Ambulatory Care will be monthly or bimonthly during the initial phases of the office development, and will be no less than quarterly once the clinic is established. Evaluation by Pharmacy, MAS, Laboratory and Nursing personnel will be conducted in consultation with the Chief Medical Officer by the appropriate program official at VAMC Martinez.

I. Staff Development

Sufficient precedent exists for the continuing education and professional improvement of practicing physicians and nurses both within the VA system, and in the private sector that little needs to be added. The office physicians will be encouraged to interact professionally in discussing cases and determining management statagems for individual patients. Administrative leave will be approved, when possible, by the ACOS/AC in Martinez VAMC for office physicians to attend continuing education conferences, lectures, courses, etc. The budget for the medical office provide for four one-week details from Redding to Martinez for the purpose of staff development and eight one-week details from Martinez VAMC to Redding to provides staff development, evaluation and back-up coverage.

J. Call Schedule

The office practice model will allow for having a physician available for consultation during nonoffice hours. This objective will be met through a commercial answering service and a pager system with a call schedule arranged at the convenience of the group. Patients who require care during nonroutine office hours will be seen at the discretion of the physician on call, either in the office or in the Emergency Room of a community hospital. A separate Emergency Room contract will be negotiated with one of the community hospitals.

K. Automatic Data Processing

Computer support for the medical office will be provided by means of a leased data line and concentrating modems as this provides the best combination of compatibility, reliability, future expansion and cost.

L. Non VA Hospitalization

Based on the experience of the Oakland and Sacramento VAOPCs, it is anticipated that there will be approximately one to seven cases per year of non-VA hospitalization at a cost of $5,000 to $25,000.

9.

M. Beneficiary Travel

Estimates for beneficiary travel assume that current beneficiary travel regulations are not changed; however, if revisions occur, actual beneficiary travel costs will be less than estimated. The average nonemergent beneficiary travel cost per outpatient visit is estimated to be $3.03 for a total annual nonemergent beneficiary travel cost estimate of approximately $46,000. Emergency ambulance travel from Redding to VAMC Martinez is estimated to be 25 ambulance trips during a 12-month period for a total emergency beneficiary travel cost of approximately $22,000 per year.

N. Telecommunications

Minimum FTS and commercial telephone services and a commercial answering service with a personal pager will be required to support the medical office.

O. Local Transportation and Courier Service

A station wagon will be leased from GSA and used for staff travel between Redding, Sacramento and Martinez. One trip per week will be made to the Martinez VAMC. A contracted daily courier service will transport laboratory specimens and results and other ancillary support material between Redding and the Sacramento OPC or VAMC Martinez.

P. Quality Assurance

Mechanisms that will provide for the monitoring and evaluation of the quality and appropriateness of patient care at the Redding clinic will be built into the program as it assumes a more definitive structure. Initially there will be frequent telephone contacts between office personnel, the Director, and ACOS/Ambulatory Care and other key people in Martinez. These contacts will be supplemented with regular trips to the clinic with the purpose of assuring that the organization, logistics and personnel are working to promote high quality health care practices. In the meantime, the Martinez QA Coordinator will be working with the ACOS/Ambulatory Care and clinic personnel to establish a criteria-based monitoring system that will address such issues as quality and appropriateness of care, completeness of medical records, use of medications, patient satisfaction and quality control in laboratory, pharmacy and radiology services. Utilization review will include a staff productivity component.

Q. Advantages of the VA Medical Office

Patients base their expectations for good medical care on what they perceive to be the practice in the private sector. The opportunity to be seen in an office setting by individuals who ultimately can be identified as "their physician" would enhance the sense that the VA is not only meeting their needs, but providing quality medical care on a par with the private sector.

10.

The proposed model also provides the opportunity for assessing the validity of current medical practice, such as prescribing medications, ordering x-rays and tests, referrals to other clinics for consultation, frequency of patient visits and need for hospitalization in a VA office practice setting versus a traditional VA clinic setting.

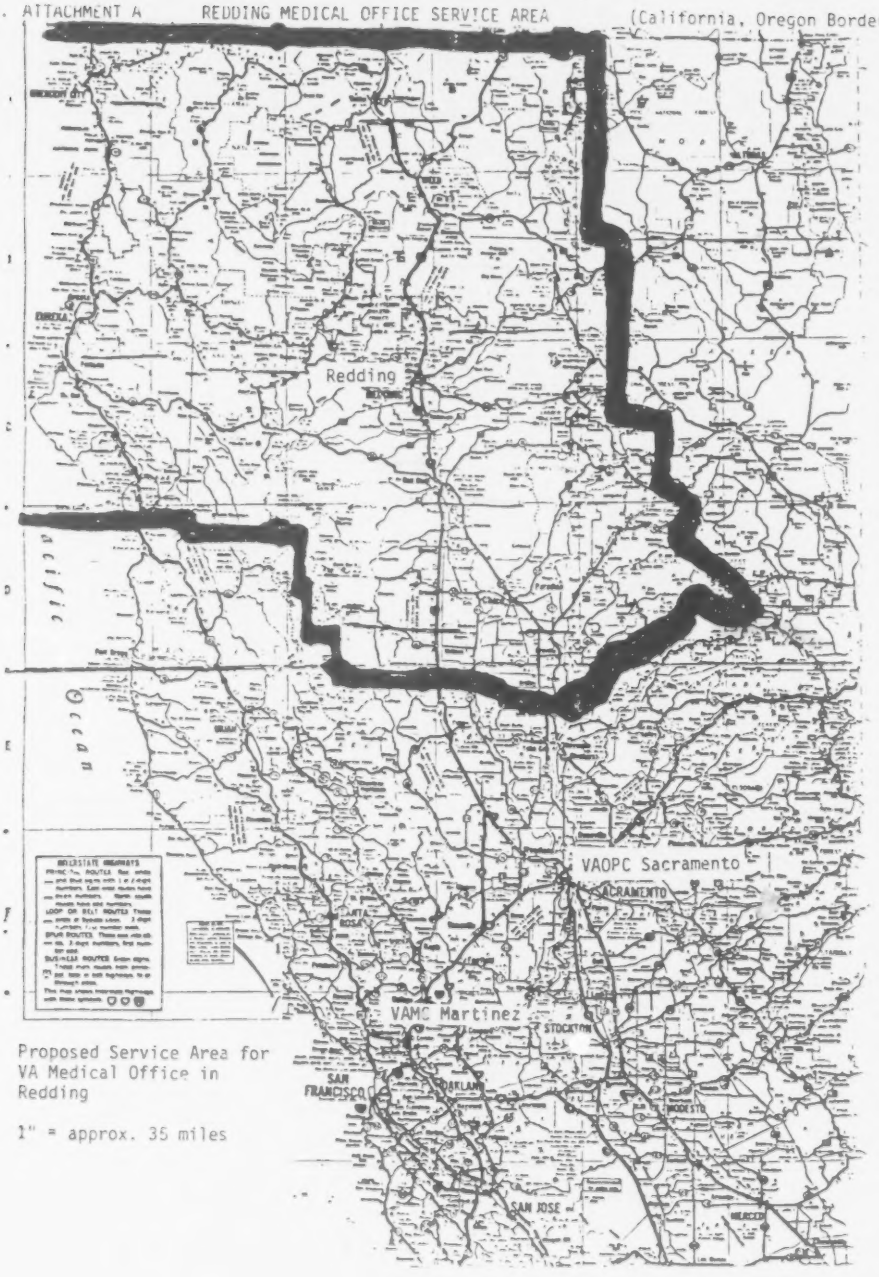
Finally, cost has been addressed in every aspect of the proposed VA Medical Office in Redding. All studies of health care costs focus on the practice habits of the physician as the singular most important determinate of cost of care. This model attempts to provide a structure in which the financial impact of these habits can be evaluated, and compared to that of the hospital-based VA physician who provides primary care to the ambulatory patient.

Utilizing leased or rented space and following the medical office model, this alternative can be implemented on a phased-in basis and expanded as necessary to meet the demand for health care by the veterans in the Northern California (Redding) area.

R. Department of Veterans Benefits Participation

The DVB Regional Office, Vocational Rehabilitation and Counseling Division, which visits the area for vocational counseling and training assistance, will also use the medical office to see veterans. The Regional Office does not have the FTE available to permanently place a veterans benefit counselor at the Redding Medical Office except on an itinerant basis. Itinerant service may be adequate for the initial phases of the project. However, when a larger patient/client base is established, additional benefit services may be needed and VA Central Office would be requested to consider the one-stop concept for the Redding area. The Director San Francisco Regional Office has been thoroughly briefed and will be provided with a copy of this proposal for DVB consideration.

11. ATTACHMENT A REDDING MEDICAL OFFICE SERVICE AREA (California, Oregon Border)



Proposed Service Area for VA Medical Office in Redding

1" = approx. 35 miles

12.

ATTACHMENT B

Proposed Budget*
for VA Medical Office, Redding

CATEGORY OF EXPENSE	NONRECURRING DOLLARS	RECURRING DOLLARS	PERSONAL SERVICES DOLLARS	FTEE
1. Core Office Personnel			590,844	14
2. Pharmacy	8,100	200,000	54,176	2
3. Laboratory	10,450	16,000	45,847	2
4. Radiology	68,400	29,000		
5. Equipment & Furniture	64,452			
6. Supplies	10,000	30,000		
7. ADP	8,180	7,240		
8. Telecommunications	7,700	5,350		
9. Beneficiary Travel		68,000		
10. Courier Service		22,000		
11. GSA Vehicle		7,000		
12. Non-VA Hospitalization		5,000 - 25,000**		
13. Medical Care and 813 Travel		7,712		
14. Space and Utilities		***		
TOTAL	$177,282	$417,302	$690,867	18

* Explanation for each account by number are listed on the following pages.

** Represents a range of estimated expenses for non-VA hospitalization.

*** Cost of space and utilities cannot be determined until negotiations begin in the Redding area.

13.

1. Core office personnel includes salary costs and FTE for four physicians, two RNs, one social worker, two LVNs, one alcohol/rehab technician, one MAS supervisor-health benefits counselor and three MAS clerks.

2. Pharmacy costs are for one FTE pharmacist in Redding and one FTE technical/clerical to provide mailout service from Sacramento OPC, $200,000 for drug costs and $8,100 for initial equipment.

3. Laboratory costs are for one FTE phlebotomist/technician in Redding, one FTE technologist at Sacramento OPC or Martinez VAMC, $10,450 in equipment costs, for two centrifuges, refrigerator, microscope, etc. and $16,000 in Laboratory supplies and contract testing fees.

4. Radiology costs include $68,400 for a portable X-ray machine, processor and table and $29,000 for x-ray supplies and contract exam fees.

5. Equipment - Office equipment and furniture.

6. Supplies - Routine supplies required for examining and treating patients.

7. ADP - Four computer terminals, two printers and leased line fees.

8. Telecommunications - FTS and commercial telephone service and a paging and answering service.

9. Beneficiary Travel - Emergent and nonemergent beneficiary travel.

10. Courier Service - Daily transportation of laboratory specimens, medical records etc. between Redding and Sacramento OPC or Martinez VAMC.

11. GSA Vehicle - A leased station wagon for local travel and staff travel between Redding, Sacramento OPC and VAMC Martinez.

12. Non-VA Hospitalization - Estimated at one to seven cases per year.

13. Medical Care and 813 Travel - Travel and per diem for details between Redding Office and Martinez VAMC for continuing education, evaluation and supervisory visits from VAMC Martinez.

14. Space and Utilities - Unknown at this time. After a proposal has been approved negotiations will begin in the Redding area.

ATTACHMENT C

ESTIMATED RESOURCE ALLOCATION METHODOLOGY REIMBURSEMENT FOR 15,000 VISITS
FOR A VA MEDICAL OFFICE IN REDDING, CA

	Visits	÷	National Visit/pt	=	Pts	x	20%	x	National WWU/Pt	=	WWUs
Standard Patient Visits	13,000		3.87		3,359.17		671.83		269.51		181,066.15
High Medical Visits	1,200		17.3		69.36		13.87		1,278.89		17,741.82
Mid Psych Visits	800		10.48		76.33		15.26		771.53		11,779.08
Total Visits	15,000							Total WWUs			210,587.05
							FY 87 National Reimbursement Rate			x	$4.05
								Total Reimbursement			$852,878.00

RAM Reimbursement

10,000 visits = $568,870
15,000 visits = $852,878
17,500 visits = $994,882
20,000 visits = $1,136,886

15.

ATTACHMENT D

EARNED/SPENT ANALYSIS

A summary of the estimated budget and Resource Allocation Methodology reimbursement figures from the preceding pages for the VA Medical Office in Redding show the following:

Total Nonrecurring costs = $177,282
Total Recurring costs = $417,302 (excludes space and utilities)
Total Personal Services costs = $690,867

Total start-up and budget for 12 months for 15,000 visits (excluding space and utilities) = $1,285,451

Of the $1,285,451 total cost approximately $916,371 is direct medical care costs and $191,698 is indirect costs excluding rent and utilities; $177,282 is for initial furniture, supply and equipment purchases and $25,000 for non-VA hospitalization estimated for one year.

Total Resource Allocation Methodology (RAM) reimbursement for 15,000 visits equals $852,878. RAM reimbursement of $852,878 minus $916,371 direct expenses equals a -$63,493 loss under the RAM. RAM reimbursement for 17,500 visits equals $994,882. RAM reimbursement of $994,882 minus $916,371 direct expenses (no change in costs from 15,000 visits) equals a $78,511 positive gain under the RAM. It is projected that the break even point under the RAM for the Medical Office will be reached at 16,000 visits.

An additional method of looking at costs and the relative efficiency of the medical office is to compare the recurring direct and indirect cost per visit at the proposed Redding VA Medical Office of 73.87 for 15,000 visits (exclusive of rent and utilities) to the national cost per outpatient visit of 86.09.

Under the two methods of looking at costs and reimbursement based on preliminary budget estimates and outpatient visit estimates for 17,500 visits per year, it appears that the medical office model can be cost-effective.

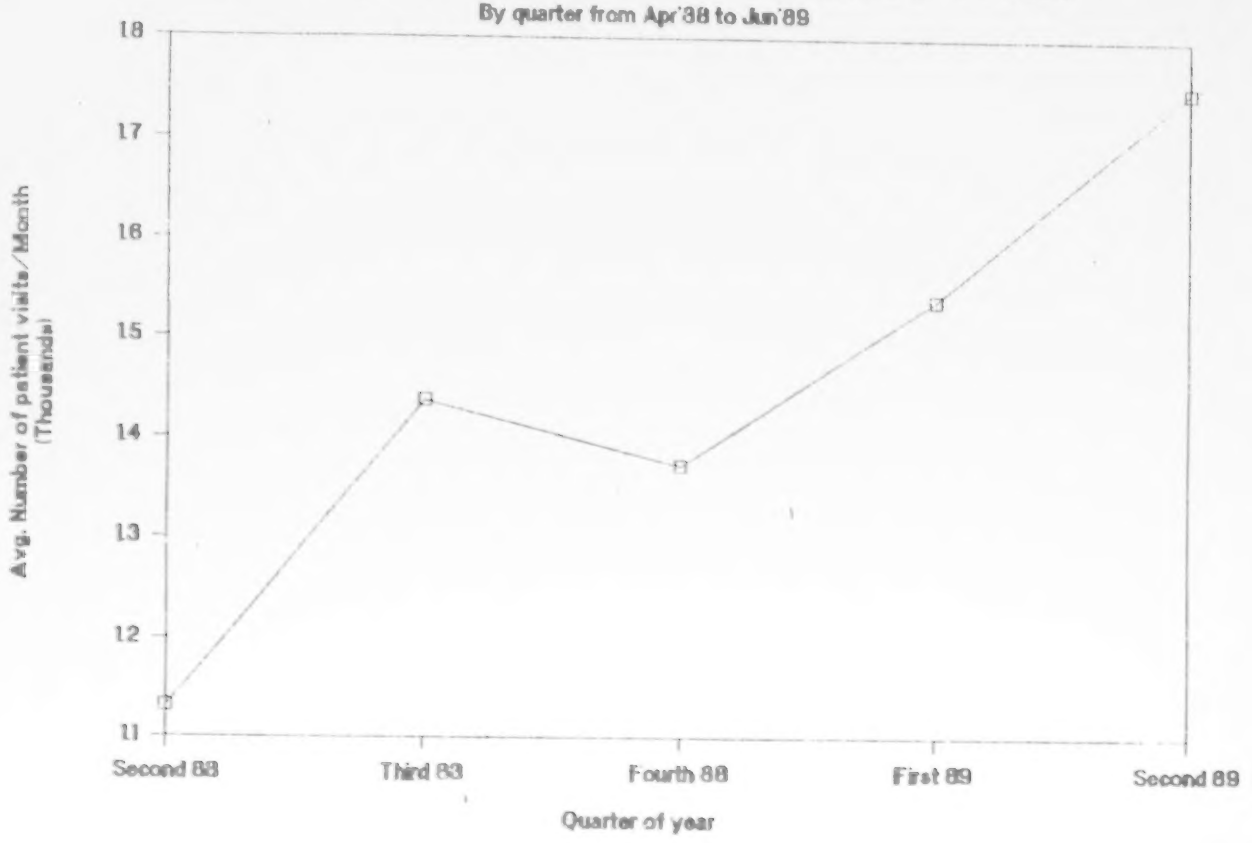
ATTACHMENT F

REDDING WORKLOAD
(MARTINEZ VAMC)

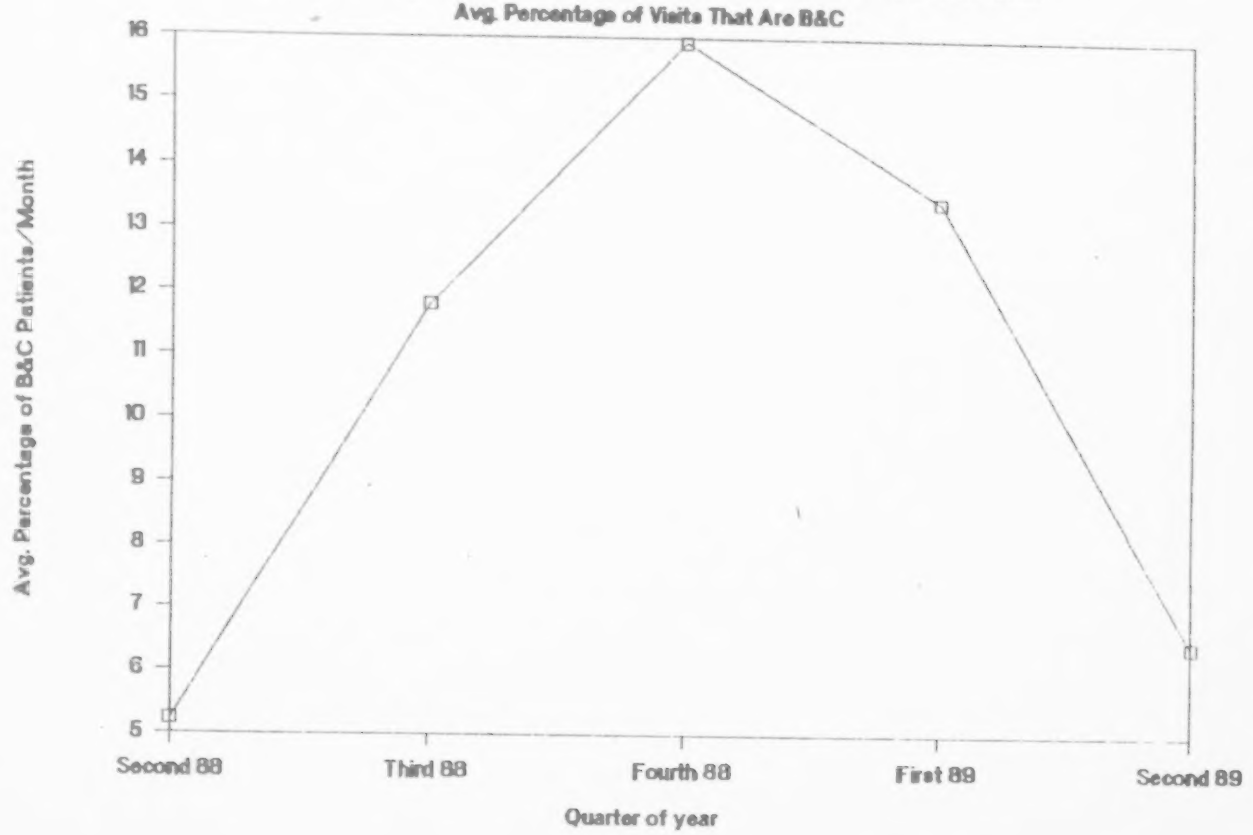
MONTH	PATIENT VISITS	CAT. A	CAT. B	CAT. C	NON-VET	% of PATIENT VISITS THAT ARE B & C	% of PATIENT VISITS THAT ARE B, C & NON-VET
APR '88	578	374	9	13	12	3.8	5.9
MAY '88	1498	973	32	57	65	5.9	10.3
JUN '88	1317	831	38	41	96	6.0	13.3
JUL '88	1299	976	46	63	65	8.4	13.4
AUG '88	1538	1198	88	121	34	13.6	15.8
SEP '88	1475	1116	88	110	40	13.4	16.1
OCT '88	1429	1112	92	119	39	14.8	17.5
NOV '88	1349	1081	112	124	32	17.5	19.9
DEC '88	1341	1112	83	125	21	15.5	17.1
JAN '89	1570	1308	107	132	23	15.2	16.7
FEB '89	1456	1234	91	101	29	13.2	15.2
MAR '89	1590	1397	90	100	3	11.9	12.1
APR '89	1577	1439	48	69	21	7.4	8.8
MAY '89	1815	1657	48	74	36	6.7	8.7
JUN '89	1859	1723	61	56	19	6.2	7.3
JUL '89	1376	1293	36	30	17	4.8	6.0

Redding Medical Office Workload Trend

By quarter from Apr'88 to Jun'89



Redding-- Category B & C Workload



ATTACHMENT I

VA CRITERIA FOR SPACE REQUIREMENTS AT REDDING MEDICAL OFFICE

PATIENT ASSESSMENT AREA AND UNSCHEDULED VISITS

	Present Workload Present Services* (in NSF**)	Present Workload Added Services* (in NSF**)	Future Workload Added Services* (in NSF**)
Waiting Area	1200	1200	2040
Restrooms:			
Men:	50	50	90
Women:	50	50	50
Volunteer and Escort Space	120	120	120
Office, Scheduling	140	140	140
Office, Travel Clerk	120	120	120
Agent Cashier	150	150	150
Compensation and Pension Clerk	50	50	50
Office, Health Benefits Advisor	120	120	120
MAS Reception-Control Processing Unit	30	30	30
Clerical Work Station/Interview Booth	130	130	130
Equipment Space:	200	200	200
Office, MAS Supervisor	140	140	140
Equip. Rm./Phone Switchgear	150	150	150
Wheelchair & Stretcher Storage	150	150	220
Housekeeping Aid's Closet	40	40	40
Nurse/Communication Station	130	130	130
Vital Signs	60	60	60
Unisex Toilet - Staff	30	30	30
Examination/Treatment/ Consultation Room	230	230	330
Security/Exam Room	100	100	100
Wheelchair Toilet	75	75	75
Social Worker Office	120	120	120
Staff,Patient Multipurpose/ Conference Room	160	160	160
Offices for Physicians	300	300	450
Office, Professional Aid	100	100	200
Clean Utility Room	60	60	60
Soiled Utility Room	80	80	80
Storage of Medical Equipment	60	60	60
Veterans Benefits/Coordinator/ Office Space	120	120	120

ATTACHMENT I

SCHEDULED CLINIC AREA

	Present Workload Present Services* (in NSF**)	Present Workload Added Services* (in NSF**)	Future Workload Added Services* (in NSF**)
Examination/Treatment Consultation Room	804	804	1140
CLINIC CARDIOLOGY LAB			
ECG	N/A	85	85
Treadmill Storage	N/A	20	20
EYE CLINIC			
Exam Room	N/A	160	160
Patient Waiting Space	N/A	50	50
Reception Clerk	N/A	90	90
Ophthalmologist Office	N/A	120	120
GENERAL MEDICINE CLINIC			
Multipurpose/Treatment Rm.	150	150	150
Wheelchair Toilet	52	52	52
MENTAL HEALTH CLINIC			
Office for Chief	N/A	150	150
Receptionist/Secretary	N/A	120	120
Counselor	N/A	240	140
Clerical Support	N/A	160	160
Rehabilitation Technician	N/A	160	160
Waiting Space	N/A	120	120
Exam/Treatment Room	N/A	120	120
Biofeedback Lab			
Control Room	N/A	100	100
Patient Treat	N/A	180	180
Group Therapy Room	N/A	320	320
ORTHOPEDIC CLINIC			
Cast Room	N/A	140	140
Storage	N/A	60	60
PHARMACY			
Includes everything except drug information center, mailout prosthetics, medical supplies	N/A	1760	1760
RADIOLOGY			
All except two toilets and housekeeping aid's closet	N/A	1760	1760
SURGICAL CLINIC	N/A	1617	1617

ATTACHMENT I

	Present Workload Present Services* (in NSF**)	Present Workload Added Services* (in NSF**)	Future Workload Added Services* (in NSF**)
UROLOGY CLINIC			
Urology Speciment Toilet	N/A	52	52
Urinary Testing Alcove	N/A	50	50
Cystoscopic Room	N/A	350	350
External Radiographic Control Room	N/A	45	45
Dressing/Recovery Room	N/A	160	160
Work Room	N/A	200	200
Scrub-up alcove	N/A	50	50
Radiographic Film Developing			
Dark Room	N/A	40	40
Light Room	N/A	60	60
ADMINISTRATIVE SUPPORT			
Warehouse-on-site	N/A	1364	1364
Bldg Mgmt Storage Area	340	340	340
Locker Room Area	516	516	616
Reproduction/Mail Room	150	150	150
Medical Transcriptionist Office Space	80	80	160
Photocopy Room	100	100	100
MEDICAL RECORDS STORAGE			
File Room	455	455	850
File Clerk Work Space	50	50	100
Physician's Workroom	80	80	80
MAS Librarian Office	100	100	100
Outpatient Clinic Mgmt Suite	450	450	450
OUTPATIENT CLINIC MANAGEMENT SUITE	810	810	930
Vending	360	360	360
TOTALS	***8,962***	***18,865***	***21,146***

* **Present Workload** is 20,000 visits/year; **Future Workload** is 34,000 visits/year in FY 2000; **Added Services** include Radiology, Pharmacy and clinics in Mental Health, Surgery, Ophthalmology, Orthopedics, Cardiology, and Urology. An on-site warehouse is also accounted for

** Net Square Feet

STATEMENT OF

VIETNAM VETERANS OF AMERICA, INC

Presented by

ARTHUR JOHN WOODS
EXECUTIVE DIRECTOR, VIETNAM VETERANS
RESOURCE CENTER, TX

and

THOMAS A. SHERWOOD
DIRECTOR FOR HEALTH POLICY AND PLANNING

before the

SENATE VETERANS AFFAIRS COMMITTEE

on

HEALTH CARE FOR RURAL VETERANS

NOVEMBER 15, 1989

Mr. Chairman and members of the Committee, the Vietnam Veterans of America, Inc. (VVA) appreciates the opportunity to present its views on Health Care for Rural Veterans.

When mainline and urban VA health care systems suffer from limited resources and an inability to provide service which results in denying veterans access to health care, veterans located in rural areas in this country tend to suffer much more than their urban brothers and sisters.

Undue hardships are experienced by a number of veterans residing in rural areas, hardships that are exacerbated many times over by some VA facilities in their practice of providing health care.

Some of the most common and most irritable sources of painful encounters veterans experience with the VA health care system in rural areas include:

Verbal abuse at the hands of some VA employees after the veteran has, in some cases, traveled literally hundreds of miles to get to a health care facility.

A distinct lack of sensitivity in some VA employees regarding hardships some rural veterans experience in trying to obtain health care services.

The loss of medical records and other clinical data for which the VA fails to warn the veteran in advance of his or her trip, and for which the veteran is made to feel

responsible in very dysfunctional ways once he or she arrives in the medical center.

The refusal of some VA facilities to interact with local providers of health care in the interest of facilitating a better health care product for the veteran.

The refusal of some VA facilities to provide the veteran quality information, explanations, or results of examinations, in order to assist the veteran who lives so far from the facility.

The inability of some VA facilities to efficiently coordinate clinical appointments so that the veteran does not have to wait literally hours after which, if the appointment has not been cancelled, it is impossible to get home without extreme difficulty.

There are a number of issues that occur which have very adverse effects on the veteran. Some of them are in the following areas.

Beneficiary travel.

Medical School Affilitations.

Contract Services.

Services for Minorities and Female Veterans.

Special Ambulatory Programs.

Relocation of Services.

BENEFICIAL TRAVEL

In many cases, after a veteran has traveled many miles to a VA facility for health care or assessment, he or she finds out that they are either not entitled to beneficiary travel, or the Center has "run out of money," or that there is a freeze on the budget, or that the Congress is in Continuing Resolution, or that the Beneficiary travel account has been exhausted, or that the veteran is not in the "correct" category, or that Gramm-Rudman-Hollings has denied them travel funds, etc.!

All of the above may bare some truth in some way at some time. But one cannot help but observe how the veteran is being hurt by all this bureaucracy. One cannot help but observe how badly the veteran who is the recipient of this mess is treated and excluded from the decision-making processes that created the mess in the first place.

Yes, we conclude that we need more beneficiary travel dollars.

Yes, we conclude that there may not be enough resources to go around.

Yes, we conclude that there is some robbing Peter to pay Paul. But if we expect to really correct this situation and truly be of assistance to our customers, we need to

conclude that there is more of a problem than just money. One of the main problems is that the veteran is not a part, in a meaningful way, of the system he or she uses at the functional delivery level.

MEDICAL SCHOOL AFFILIATIONS

Perhaps few relationships point out the differences between VA urban and rural Veteran health services programs better than those differences involving affiliated and non-affiliated VA medical centers.

Non-affiliated Centers by virtue of their smaller budgets have a decreased opportunity to serve rural veterans. In addition to limited budgets while positioned to have greater contact with rural veterans, they will have a decreased opportunity to have a highly specialized technical staff and corresponding programs. At the same time rural veterans, like their urban brothers and sisters, still have essentially the same health care needs.

This is not to say that rural non-affiliated VA medical centers cannot deliver a good health care product. This is to say that we are unable at this time to discern positive effects on the veteran directly as a result of the relationship between these two types of institutions. In appearance at least, it exactly the opposite. The large VA tertiary affiliated hospitals along with other medical centers

need to develop through the regions, catchment area based planning systems of care that assures quality health care to rural veterans. This plan should identify every veteran using the system in the catchment area, regardless how remote, and be prepared to meet his or her health needs within the limits of the VA health care system.

At the very least, the Veterans Health Service and Research Administration (VHS&RA) needs to be in a position to share with the veteran, with some degree of compassion, why it is unable to care for him or her based on some rational planning system in the attempt to provide that care.

CONTRACT SERVICES

It appears the first programs that get hit when there is a budget squeeze are in the area of Contract programs. These programs include those in nursing home care, other programs involving beds outside of VHS&RA occupied by veterans for which the VA has fiduciary responsibility, and certain ambulatory care programs which are provided in the private sector to veterans.

It is in this area in particular, rural veterans are disproportionately hurt. When the VA in the last fiscal year withdrew dollars from private sector contracts in the readjustment counseling program account, the resulting

limitations PTSD and other mental health care for veterans was nothing short of being disgraceful.

Some contract providers of readjustment counseling and PTSD services continued to provide care for some veterans without knowing when they would be paid rather than simply dropping the veteran from treatment. For some of these Providers and the community at large, the credibility of the VA was severely and even permanently damaged. For the veterans, as a result of these VA actions in some cases, illnesses became exacerbated.

Obviously, we cannot continue to be in a hurtful environment of unmanaged uncertainty involving misdirected priorities which appear to meet agendas that are not in the veteran's best health care interest.

It is also apparent that the highly centralized VHS&RA system in meeting its national agenda, must be sensitive to local need. Through this, they may appreciate the havoc razed on rural veterans by cutting a relatively few dollars considering the size of the multibillion dollar overall budget of the VA health care system.

SERVICES FOR MINORITIES AND FEMALE VETERANS

There is considerable documentation indicating the VA's limited role in delivering health care services to Native Americans who are, for the most part, located in rural areas.

This documentation is found in the final report of the Veterans Administration Advisory Committee On Native American Veterans dated February 1, 1988, the Department of Veterans Affairs own report on Native American Veterans dated Februrary 1, 1989, and in the Press as well.

Women veterans and other minority veterans, as in the case of Native American Veterans, who in some cases do not feel that they are welcome in the VA health care system, have a distrust of the the system, in part, because of the negative treatment some of them have received at the hands of the system.

These problems coupled with living in rural areas where limited VA outreach takes place, clearly signals to the veteran to stay away unless they are critically ill. In some cases, when the veteran finally comes into a medical facility, they are beyond help.

This limitation of the VA to reach out to veterans even extends to incarcerated veterans who should not be denied care if they have earned the right to that care. As a result of these compounding effects, minority veterans living in rural areas suffer at least as much as majority veterans in these areas if not more. However, the real issue is that all of these veterans suffer needlessly by the VA's health care system in rural areas.

The establishment of a position such as Assistant Secretary for Minority Affairs within the Department of Veterans Affairs could go a long way to deal with this problem if such an office coordinates with VHS&RA. But what the VA will have to do if it wishes to be effective in dealing with this problem is to include veterans at the service and local level in the solution.

Previous testimony we have given before this Committee has made recommendations as to how veterans can be included in the process relative to the issue of decentralization. We will be happy to resubmit those suggestions to you.

RELOCATION OF SERVICES

Many veterans at the State and local level have expressed great concern that VHS&RA makes very important health care program decisions involving either relocation or elimination of services without the input of those who are directly effected by those decisions. This is especially true regarding rural veterans where such decisions can have a major impact on the quality of veterans health care in outlying areas.

One of many examples of this concern comes out of Huntington, West Virginia where a 66 million dollar addition is planned at the VA Medical Center involving the creation of psychiatric beds but does not include PTSD beds which local

veterans need and have asked for. In States such as New Mexico Michigan, Washington, and others for which VA Joint Ventures or other related projects are either on-going or planned, active support, cooperation, and input should be solicited by the Veterans Administration from veterans in these areas.

We are fully aware of the political implications for these "Projects" in the communities in which they finally come to rest. We are pleased if these VA projects meet both the political objectives of Congressional Representatives and the veteran who require theso services, but not at the expense of the first priority, namely, the Veteran's health care needs.

We believe it is essential and in the best interest of the VA that veterans at the local level have meaningful and significant input relative to the determination of where and why VA health care services take place.

SPECIAL AMBULATORY PROGRAMS

Veterans located in all areas, but particularly rural areas, express considerable dissatisfaction with the VA Medical Centers apparent inability to share with them information pertaining to special programs, such as Agent Orange examinations and the Registry, laboratory and examination findings and results, preventative health care.

To quote some veterans, "it's like pulling teeth to get any information out of those people." This difficulty with regard to the service delivery aspect of the VA's Agent Orange program was well documented by various Veteran groups and other interested citizens in the testimony they gave before the Advisory Committee on Health-Related Effects of Herbicides on October 31, 1989. We strongly recommend that this Committee obtain the actual transcripts (as opposed to a summary of the proceedings) and witness for yourselves the concern expressed on behave of all Veterans. Be assured that Rural Veterans by virtue of some of their difficulties noted in this Testimony are doubly effected.

Ultimately therefore, especially in the case of rural Vietnam Veterans, they simply give up on the System and in some cases, stay home getting sicker rather than travel the many miles and suffer anxiety-producing encounters with the Veterans Administration.

Given the above testimony, it is our sense that the Department of Veterans Affairs is aware of some of the issues raised here affecting rural veterans health care. We are aware that the Department (VHS&RA) has provided for some additional services which effect rural veterans. There has been, for example, an increased number of PTSD teams, Outreach Centers, the targeting of certain medical centers to deal with

the dual diagnosis issue and the creation of the PTSD Clinical, Research, and Educational Center between several medical centers.

But there are major programs and program proposals involving large capital expenditures, political committements, and what is believed to be programs presumably worthy of only Congressional, Executive Branch, and Veterans Services Organizational Leadership (to the exclusion of veterans in the field using these programs) that effect both rural and urban health care.

It is in these areas where the "big players" will have to become more sensitized to local and rural veterans health care needs and allow for much more functional input from those who actually utilize the services.

The following suggestions to improve Veterans rural health care could go a long way to manage a situation which could easily deteriorate into a serious case of bad medicine provided to customers by a company who has truly forgotten that the customer is the only reason for that company's existence.

RECOMMENDATIONS

THERE IS A NEED FOR AN OVERALL RURAL HEALTH CARE PLAN INVOLVING AT LEAST THE USE OF SPECIAL MEDICAL TEAMS AND, IN

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APPROPRIATE SITUATIONS, MOBILE HEALTH CARE FACILITIES.

THERE IS A NEED FOR THE VA TO OUTREACH WITH RESPECT TO INFORMATION, INSTRUCTIONS, PLANNING, APPOINTMENT SYSTEMS, AND COORDINATION OF HEALTH CARE TO RURAL VETERANS.

THERE IS A NEED FOR THE VA TO INTERACT AND MORE EFFICIENTLY AND EFFECTIVELY COORDINATE WITH LOCAL COMMUNITY AND PERIPHERAL HEALTH CARE SYSTEMS FOR ALL VETERANS WHO MUST USE THESE SYSTEMS AND ARE ENTITLED TO SUCH SERVICES.

THERE IS A NEED FOR THE VA TO INCLUDE AND NOT EXCLUDE THE VETERANS IN RURAL AREAS IN THE DECISION-MAKING MAKING PROCESS, ESPECIALLY WITH REGARDS TO PROJECTS INVOLVING JOINT VENTURES AND THE PROVISION OF CARE BY OTHER AGENCIES FOR THE VA.

THERE IS A NEED FOR THE VA TO DO INSERVICE TRAINING TO INSTRUCT VA EMPLOYEES, ESPECIALLY HEALTH CARE PROFESSIONALS AND MEDICAL ADMINISTRATIVE SERVICES STAFF, IN THE AREAS OF CUSTOMER RELATIONS, RECORD MAINTENANCE AND TRACKING, VETERANS CONCERNS AND ISSUES, AND VETERANS BENEFITS AND ENTITLEMENTS. INFORMATION PACKETS SHOULD BE PROVIDED ON ALL OF THESE TOPICS SO THAT THE VETERAN KNOWS WHAT THE PROVIDERS OF VETERANS SERVICES HAVE BEEN EXPOSED TO AND WHAT IS EXPECTED OF THEM.

We thank you for this opportunity to testify before you and the members of Veterans Affairs Committee.

STATEMENT OF

JAMES M. POWELL, ACSW

Chief, Social Work Service

Veterans Affairs Medical Center

Beckley, West Virginia

Before the

Committee of Veterans Affairs

United States Senate

in regards to

Access to Health Care Services

on

November 15, 1989

Mr. Chairman and Members of the Sub-Committee:

On behalf of the VA Medical Center at Beckley, West Virginia and its Director, Mr. D. R. Pisegna, I wish to thank you for including us in todays hearings.

Our medical center serves eleven (11) rural counties in southern West Virginia and one county in Virginia. With the exception of Raleigh County, medical and health services are limited. For example, Pocahontas County has one hospital with 40 beds to serve 9,200 residents, 1,100 of these are veterans. Wyoming County, which has a population of 33,000 has no hospital. The veteran population is 3,400. There is a lack of services for the chronically ill that require specialized treatment. Veterans that are ventilator dependent but stable have no available resources except continued hospital care. Geropsychiatric patients are not accepted into community nursing homes because they often exhibit "unacceptable" behavior; leaving families to care for these patients 24 hours a day, usually without any available community resources to assist them. To complicate matters, in order to receive medical treatment many individuals have to travel a considerable distance. These areas have no public transportation and commercial bus service is limited to interstate routes, thus leaving private transportion as the only available option. And if you're poor and disabled you often don't have a private means of transportation.

Ninety three percent of our patients are Category A veterans; they are service connected or on a limited income. If these individuals did not have access to care through the VA many would simply not receive adequate care from the community based health care system.

At the VAMC - Beckley we have tried to address some of the problems faced by veterans living in rural areas.

For veterans requiring more care than can be provided in a Skilled VA or community nursing home program we have developed an Intermediate Medical Care Unit. This sixteen bed unit provides specialized medical care for veterans who are not acutely ill but require more medical attention than can be provided in a nursing home. We have also initiated a Respite Care Program to support caregivers so that veterans may remain in their homes. Veterans are admitted to the VA at planned intervals to allow caregivers a period of rest and an opportunity to receive necessary medical treatment for themselves. Respite Care is not available outside the auspices of the VA in our catchment area. We provided 197 days of respite care in FY1989 enabling 16 veterans to remain in their home and helped prevent physical and emotional burnout of the primary caregivers.

Respite Care and Intermediate Medical Care are unique offerings in VA Medical Centers; without these programs many veterans would not receive adequate assistance because resources are not available in their communities.

In order to address the transportation problem faced by many veterans, the VAMC and the Disabled American Veterans of West Virginia have entered into a cooperative agreement to help veterans with their transportation needs. The VA provides office space and telephone access, and the DAV provides personnel and funding to coordinate a transportation network. This network provides services to all twelve counties in our catchment area helping eligible veterans access the Medical Center's health services. Social Work Service and the DAV Coordinator work cooperatively to assure appropriate referrals are made. Approximately thirty-five patients are assisted monthly. This service is especially valuable to veterans on a limited fixed income. There have been cases where NSC pensioners have had to pay 10% of their monthly income to be transported to one outpatient appointment. The DAV

Transportation Network helps stop this type of price gouging by providing veterans with an alternative transportation source and helps veterans keep follow-up medical appointments.

Mr. Chairman, VA Medical Centers are a major component of the rural health care system. Continued support of community based programs like the contract nursing home programs, joint cooperative ventures such as the VA-DAV Transportation Network and the continued development of innovative inpatient health services such as respite care and intermediate medical care will ensure that veterans receive the care they need.

I would like again to thank you on behalf of the VA Medical Center Director, Mr. Pisegna, for inviting us to present our views.

Francis P. Goldstein, M.D.
Associate Chief of Staff for Ambulatory Care
Wm. Jennings Bryan Dorn Veterans' Hospital
November 15, 1989

Testimony to Senate Veterans' Affairs Committee

Rural Veterans' Health Care

South Carolina ranks 27th in the nation in the urban/rural ratio of the population (1980 census). Forty-six percent of our citizens reside outside of urbanized areas of 2,500. Although the Department of Veterans' Affairs (DVA) does not publish similar data for its beneficiaries, there is no reason to suspect that this subpopulation differs significantly from South Carolinians as a whole. Thus, we estimate that out of the 352,000 veterans who reside in our state, approximately 162,000 live in rural areas as defined by the Census Bureau.

The DVA operates three medical facilities in the state: there are hospitals in Columbia and Charleston and an outpatient clinic in Greenville. In addition, veterans in the western portion of the state make extensive use of the VAMC, Augusta, Georgia and three counties in the eastern section are part of the primary service area of the Fayetteville, NC hospital. These medical facilities are located in the most urbanized regions of the state.

BARRIERS TO HEALTH CARE

Although we are not a large state (30,225 square miles) and we have no natural barriers to transportation, residents of the rural regions of South Carolina face a number of impediments when seeking health care from the Department.

South Carolina as a whole does not enjoy a surplus of medical facilities or manpower. The Department of Health and Human Services has designated all or portions of every county as medically-underserved areas, and 80 percent of the counties are also designated as Health Manpower Shortage Areas.

Although we live in the automobile age, distance is often a barrier. Within the last year, Medical District 9 performed a study of access to DVA care in eastern South Carolina and southwestern North Carolina - a very rural area. Out of 27 counties in the region, 40 percent of the population (approximately 70,000 veterans) lived more than 60 miles from a DVA health care facility. Again, although precise studies have not been made, we can extrapolate from Census Bureau figures that approximately 211,000 veterans live in South Carolina outside of the metropolitan centers where the Department's health care facilities are located.

Economic factors doubtless play an important role. In June, 1988, the unemployment rate in the urban counties cited above was 3.6 percent, compared to 5.6 percent in the rural counties. Presumably, rural veterans are older, sicker, less likely to have private health insurance and suffer from lack of access to alternate sources of care. This population tends to

have fewer personal resources than the average in what is already a poor state. Per capita income for the state as a whole was $11,287 in 1986 (Southeast: $12,695, US: $14,636). Some rural areas fare much worse - as low as $6,950 in Lee County. The names of the places may sound quaint and charming: Honea Path, Due West, Sycamore, Society Hill, Heath Springs, Fountain Inn, Yemassee, - but in every case the residents of these isolated villages have average incomes less than $7,000 and in some cases less than $5,000 per year. Families below the poverty level are congregated in a belt that runs from the northeast to the southwest of our state and which encompasses the most rural areas of the state.

The 1987 Survey of Veterans (U.S. Bureau of the Census) polled a cross-section of veterans who had not sought care from the Department. Only 8.5 percent cited "living too far" as a reason for not making use of VA services. Surprisingly enough, however, the survey found that among those beneficiaries who might use our facilities, only 41 percent knew that the Department provided hospital care for veterans with low incomes, 48 percent knew that outpatient care was available and 34 percent knew we had a Dental Service. The further one lives from the medical centers and the big-city media, the more difficult it may be to obtain accurate and timely information about medical benefits.

Thus distance, poverty and ignorance are the three major barriers that restrict our veterans from seeking health care.

CURRENT INITIATIVES

Traditionally, medical services have been made available to veterans in South Carolina either through DVA hospitals, outpatient clinics and/or on a fee basis.

Medical Centers are located in urban areas. Those in Charleston and Augusta are tertiary care facilities. Columbia and Fayetteville are secondary care hospitals with some tertiary care services. Most are affiliated and feature a broad range of services and levels of care ranging from outpatient clinics to nursing home care.

The Greenville Clinic offers primary medical and psychiatric care with little in the way of ancillary services or specialty clinics. It is located in the heart of a metropolitan center. Within the next two years, additional outpatient facilities will become available with the expansion of the Greenville clinic and the activation of the Savannah, Georgia clinic.

Fee basis care is available to veterans who, by reason of age or health or distance are unable to seek staff care; however, eligibility criteria for fee care are relatively strict and only a very small percentage of the total veteran population qualifies. In addition, the mechanism for reimbursement to hospitals for fee care has changed dramatically in the last two years. Whereas these obligations previously were "passed through" to an allegedly inexhaustible account outside of the medical centers, the program has recently been decentralized and bills must now be paid out of the facilities' operating budgets.

The incentive is clearly to promote staff care as a means of controlling expenditures. Our own hospital, as an example, has reduced the number of veterans enrolled in this program by 50 percent in the last year.

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Given these constraints, a number of solutions are available. "State of the art" tertiary-care medicine is available in South Carolina's major medical centers. It is not transportable. If veterans are to benefit from its knowledge and technology, they must make their way to the urban centers. A number of programs are available to assist them. In FY 1989, our facility paid $650,000 in beneficiary travel, of which approximately half was for mileage, bus, hired car or other means of transportation for rural veterans. We also are in the debt of the Disabled American Veterans whose 58 volunteer drivers logged over 41,000 miles last year transporting patients back and forth from our hospital. Both the Columbia and Charleston hospitals provide daily van service for patients who live approximately 100 miles away. In certain areas, outreach programs have been developed specifically for the rural veterans: our hospital has spent nearly $1.5 million dollars in the last two years on home health services for patients who were unable to travel to Columbia for nursing visits; our social workers visited over 1000 patients at home throughout the state last year to follow up on periods of hospital care. Unfortunately, outreach is an expensive undertaking which benefits few patients while consuming resources which are often in critically short supply.

Outpatient Clinics are often cost-effective and have grown in popularity in the Southeast. The plans for the Savannah and the renovated Greenville Clinics reflect a dedication to a high level of quality care, offering a wide range of services such as subspecialty clinics and modern laboratory and radiology facilities. However, as these facilities become more intricate, they tend to require ever larger population bases to justify and support the expenditures of resources. It is difficult to propose building clinics in counties like Allendale or McCormick, both of which have veterans populations less than 600, when the same resources can be used to upgrade facilities in Greenville which is conveniently located in a region that is home to over 70,000 veterans. There are a few examples in the DVA system of small-scale clinics, - essentially doctors' offices -, but even these require population-densities greater than those found in many areas of our state and they present certain quality of care problems by attempting to treat patients in settings far removed from the usual hospital resources.

Fee basis care may be an option for certain veterans. However, there are many regions of the state which do not have enough health professionals for even the non-veteran population. The Department has unfortunately nurtured a certain reputation with private physicians for delayed payments, disallowed claims and arbitrary rate schedules which make many practitioners less than eager to accept our patients. Access to fee basis care is also limited by very strict eligibility criteria which would deny care which many rural veterans now obtain from DVA staff: fully

50 percent of the patients in our Ambulatory Care department are receiving treatment for nonservice-connected conditions. Typically, once the veteran reaches a DVA facility, his eligibility for outpatient care depends to a large extent on the clinical judgment of the physician as to whether treatment will obviate the need for hospitalization. Thus, in a state like ours where 96 percent of the nonservice-connected patients are "non-discretionary" by virtue of low income and where community resources are not in abundance, the DVA hospital has become the "safety net" for that segment of the population who overcome the obstacles cited above and manage to appear at the Evaluation Clinic check-in desk. This very discretion, which is the expression of the humanitarian conscience of the Department and the people such as yourselves who write the laws under which we operate, does not exist in the Fee Program.

*

One crude but important method of comparing access is to measure the rates at which rural and urban veterans use DVA clinical services. In FY 1988, there were 19,674 discharges from Region 2 and Region 3 VAMCs of South Carolina veterans. The discharge rate (expressed as number of discharges per 100 veterans) varied widely by county, from a low of 2.8 percent to a high of 14 percent. Presumably, rural veterans with barriers to access would make less use of DVA hospitals. In reality the average hospital discharge rate for the urban regions immediately adjacent to a DVA facility was 5.5 percent and for the rural counties 9.7 percent.

Similar, though less significant, data reflect access to outpatient care. For the same urban counties, there was an average of 0.93 clinic visit per resident veteran in FY 1988. Veterans in rural counties logged an average of 1.12 visits per veteran.

Thus, in spite of the problems involved in getting to a DVA facility, the system appears to work. The patients get to the doctors. Whether all of them, or enough of them, manage to obtain the services they require, is a question that remains unanswered. We study demand for care; I am not aware of any method to measure need for care.

FUTURE EFFORTS

I am a clinician, not a health care planner. I can research and cite statistics. I hope that I have been able to provide you with at least a brief overview of the situation in my small corner of the field. I do not claim the expertise to devise solutions.

I believe that the DVA recognizes that there are barriers that impede rural veterans in South Carolina from obtaining medical services conveniently and reliably. We have tried various means to make our facilities more accessible, including van service, volunteer drivers, reimbursement for beneficiary travel and outreach programs for those who cannot manage to reach the hospital or clinics. Future efforts will require guidance (and resources). We may consider improving our provisions for transportation; this would require vehicles and operators. There are pilot programs and legislative proposals to encourage

linkages and joint clinic ventures between DVA and established DHHS Rural Health Initiatives, military clinics, county health departments, etc. There have also been proposals to extend the Fee Basis Program to additional categories of veterans. These are all expensive propositions. Medical centers, for all their inherent faults, possess economies of scale.

Finally, I am fascinated by the survey which I cited that asked veterans why they did not use DVA services. Perhaps, before we contract for more vehicles or clinics or doctors, we should make an effort to just go out and talk to our veterans - tell them who we are and what we do, educate them a little bit about the benefits with which this country has entitled them, show them the wizardry of our technology, let them feel the care and the commitment that comes with the laying of hands. If it is not the most cost-effective solution, it is certainly the most humane.

STATEMENT OF DAVID ENGSTROM

ASSISTANT DEAN AND ASSOCIATE PROFESSOR OF MEDICINE

MICHIGAN STATE UNIVERSITY'S COLLEGE OF HUMAN MEDICINE

November 15, 1989

Mr. Chairman and Members of the United States Senate and Committee on Veteran Affairs:

Thank you for allowing me this opportunity to share perspectives on Rural Health Care delivery to Veterans with you this morning. My name is David Engstrom. I'm a board certified Internist serving as Assistant Dean and Associate Professor of Medicine with Michigan State University's College of Human Medicine. I am also Executive Director of Saginaw Cooperative Hospitals, which serves as a community campus of that medical school. My qualifications in speaking to you this morning relate to the fact that I grew up in North Dakota, the son of a surgeon in a small community. After attending medical school and completing my residency training, I joined the staff of the Fargo Veterans Administration Medical Center. I served approximately 13 years working for the Veterans Administration in positions that ranged from a resident-in-training, through a staff position, to Chief of Staff and, finally, as Director of the Fargo Veterans Administration Medical and Regional Office Center. I left that position approximately 1 year ago to enter the academic position that I have today.

I would be remiss if I did not start out by telling you that I've never worked with a more dedicated group of people than those with whom I dealt within the Veterans Administration and, in particular, a number of people in the facility in Fargo.

Determining exactly what Rural Health constitutes in not a simple endeavor. Many of you may anticipate that health care delivery in Fargo, North Dakota, is in fact very "rural". The truth is, the Veterans Administration facility is only 1 of 5 hospitals in the Fargo, North Dakota/Morehead, Minnesota metropolitan area that offers primary, secondary and tertiary care, up to and now including renal transplant surgery (within the last year). This broad spectrum of services demonstrates the diversity and sophistication that exists in some "rural" areas.

Patients at the Fargo Veterans Administration Medical Center had expectations that were in line with those of the broader community in terms of quality of care and breadth of services. I'm not stating that we could always meet these expectations; but in fact, to a large extent, the Veteran population has expectations that are shaped not only by the congressionally mandated services, but also by the level of service in the "community." In fact, even in a legal sense, our care was judged by the yardstick; that is, the law recognized as "the standard of care in the community."

At the other end of the spectrum are Veterans who live in remote areas in our PSA — those Veterans who we felt were living in the "rural" areas and who had significant needs for health care that were unmet. These people were separated by geographic barriers of hundreds of miles. They may or may not have had any access to primary care facilities within their home communities or counties. Their initial expectations for tertiary care may have been somewhat lower; however, once they access the system and arrive in a community where tertiary care is being delivered on an everyday basis, their expectations tend to change toward higher levels of care. This is especially true in situations where health care problems are threatening their very existence or their livelihoods.

Other witnesses will have noted the significant issues relating to services mandated by Congress without requisite follow-up funding being made available. Or, in some cases, funding is made available only some time after the commitment is made to provide the services. That in itself creates a problem managerially within the facilities. As important as this is, there is another issue that I wish to address. That is the effect of changes in funding of all private sector rural hospitals over the last few years on those Veterans Administration facilities which provide health care to the same populations. That change in funding has created a significant increase in demand for

services at the Veterans Administration. Now, we not only have an individual who comes from 200 miles away where his local physician does not provide chemotherapy and, therefore, the patient was referred to our facility for his cancer treatment; but there is also a new demand for services by Veterans who otherwise would have utilized local facilities but can no longer find the services as readily available due to local hospital cutbacks or closures.

Many different attempts have been made to try to deal with the remoteness of certain portions of the population whether they be Veterans or Non-Veterans. There is the utilization of out-patient or satellite clinics. There has been development of mobile systems with health care professionals who travel to the population; and there have been experiments in providing services within the private sector at Veterans Administration expense.

All of these modalities present questions regarding their cost and effectiveness in one setting or another. Perhaps some of the questions relate to the delivery of health care within any rural setting beyond the level of primary care.

Clearly, dollars cannot be made available in an unlimited amount with the idea of solving this problem — it just won't work. But one of the things which I was advised to do in preparing remarks for your group

was to perhaps make some suggestions that might be thought of to help improve the systems as they exist. With that in mind, I would give you the following perspectives:

1. To develop groupings of facilities within geographic areas much like that of District 18, where Fargo participated. By happenstance, District 18 turned out to have one tertiary care hospital in Minneapolis, two smaller primary, secondary and selectively tertiary hospitals in Fargo and Sioux Falls, South Dakota and a single neuropsychiatric facility in St. Cloud, Minnesota. From my vantage point then, and reinforced today, it was clear that the leaders of the district organized the facilities in order to potentiate the services available throughout the district, which included all of Minnesota, North Dakota, the eastern portion of South Dakota, and a small bit of Wisconsin. Because of the clustering of the hospitals and because there was not a whole lot of overlap, there were many issues that we did not have to deal with that allowed us to selectively determine where demand dictated that we develop advanced services in the 2 smaller facilities in Fargo, North Dakota and Sioux Falls, South Dakota, yet maintain much of the tertiary care capability within the facility at Minneapolis. I would encourage you to consider some type of clustering and

planning by people such as Mr. Tom Mullon and Dr. Randy Petzel in Minneapolis. They, along with people from the individual facilities, made significant effort to plan for our grouping of hospitals in a non-parochial fashion and, in retrospect, were significantly successful.

2. Politics are a reality within the Veterans Administration system which cannot be changed; however, Congress could take care to avoid mandated changes in services until resources were specifically made available, whether they be shifts in existing resources or new resources depending on particular programs. And, finally, I would recommend that steps be taken to allow local management more authority to manage. I realize that this would also dictate a need for specific accountability by local managers. However, because the resources within every community and region are different, local networking within the medical communities which would avoid duplication of services and allow shared resources could maximize efficiency. There needs to be local authority to pursue these endeavors. I realize that there is a managerial study which is on-going at this time. It is a 3-year pilot program being run in, I believe, six facilities; however, it's expected to run another two years before any decisions are made. I would point out

that the health care system is changing at a rapid rate. Because of the negative effects of various funding policies on rural facilities to date, if the Veterans Administration does not allow and encourage aggressive management of resources, the Department will simply be further behind in another two years when the demographics of the population have shifted in terms of increasing age debility.

Based on my personal experience, I found that there were times when we never felt we had enough resources to start with; however, we tried to be imaginative and to pursue things such as development of out-patient clinics in remote areas in conjunction with the existing private sector medical facilities or sharing of resources with facilities in the private sector or on Indian reservations with the Indian Health Service for example. However, a major obstacle was that, given the fact that we were a prepaid system and the commitments to care were made prior to the budget year, our planning had to be based on estimates of what would come through the front door in terms of problems. Unfortunately, it was not uncommon for us to begin a fiscal year and get through a significant portion of it only to find out that our budget would not support the level of activity which had been undertaken. That meant that we had to curtail programs and services. The Veterans saw this as withdrawing from a promise. Our staff felt

threatened both in terms of their positions and that we were letting people down to whom we had made commitments to provide care. In essence we had a cycling of building and tearing down, building and tearing down, which unfortunately did not serve our patient population well, did not provide a stable environment for our staff and created significant uneasiness for those of us in management at the facility level, at the district levels, at the regional levels, and I'm sure here in Washington.

Today there is alot of talk about the need for the production of primary care physicians. I would point out to you that there are a number of affiliations between medical schools and Veterans Administration medical centers which, by their nature, are providing services that lend themselves to the training of primary care physicians. Our training programs in Fargo helped to fortify our staffing in that we hired some of our own resident physicians or, in many instances, allowed us by way of affiliation with the School of Medicine to hire professional staff who, because of their interest in not only providing health care but also teaching and participating in research, were drawn to our setting. Perhaps the Veterans Administration should maintain its leading role in health care education by actively pursuing quality programs in primary care education in some of those rural facilities.

In conclusion, I think the U.S. Congress can help make the Veterans Administration system more efficient and effective by:

- allowing greater management flexibility;
- encouraging creativity by local management along with appropriate accountability;
- returning to some form of planning involving groups of facilities.

STATEMENT OF SEN. AL GORE
For the Senate Committee on Veterans Affairs
November 15, 1989

I commend my distinguished colleagues who serve on the Senate Committee on Veterans Affairs for recognizing the serious problem of health care for our nation's veterans. The millions of men and women who fought and protected our country in times of peace and conflict must have access to quality health care.

On Veterans' Day I toured a new $36 million hospital that is nearing completion at the VA Medical Center in Johnson City, Tennessee. This greatly-needed, state-of-the-art facility is one step in the right direction in providing adequate health care for our veterans.

Yet, this facility and VA hospitals across the nation may not be able to provide needed medical services because funding for our nation's veterans hospitals has been slashed -- reduced dramatically year after year even while the need for services increased. In fact, some VA facilities were forced to cut back on items as basic as soap because funding was not available. Our veterans deserve better.

Each week VA hospitals must turn away nearly 9,000 veterans who need health care. The facilities are not adequately staffed or equipped. In Tennessee, veterans in rural areas are sometimes forced to travel great distances just for routine checkups, and in-patient hospital care can be hours away. At the very least, our veterans deserve beneficiary travel reimbursements.

Our veterans neither want nor need sympathy. They want what is rightfully theirs -- convenient, adequate medical care. No one is more deserving of our recognition, our thanks, and our support than our nation's veterans. The time has come to give them the fair and humane treatment they have earned and justly deserve. I know this hearing will contribute greatly to our understanding of the problems our veterans face and our ability to forge effective solutions.

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WRITTEN QUESTIONS FROM CHAIRMAN CRANSTON TO

GEORGE ANDRIES AND THE RESPONSES

Question: 1. What is the breakdown of service-connected and nonservice-connected veterans in your catchment area?

Answer: We do not have exact data on the number of service-connected and nonservice-connected for all veterans living in our catchment area. However, the following information is provided concerning the service-connected status of the individual veterans we provided service to in FY 89:

Total FY 89 Unique Veterans	5,530
Service-connected Veterans	1,984 (36%)
Nonservice-connected Veterans	3,546 (64%)
Total FY 89 Unique Veterans in our PSA	4,217
Service-connected Veterans	1,453 (34%)
Nonservice-connected Veterans	2,764 (66%)

Question: 2. What non-VA resources are available to the geographically hard-to-serve veterans in your catchment area, especially to those veterans who are furthest away from a VA facility?

Answer: Attached is a list of the hospitals and mental health centers that exist within the counties in our current catchment area. As far as Wyoming is concerned, the Wyoming Hospital Association has indicated that statewide, Wyoming hospitals have operated with a negative operating margin for the past two years. Veterans falling within the income guidelines of Category A level and who have been unable to utilize VA facilities because of distance, have continued to place a great financial burden on this already overtaxed health care system. As far as mental health is concerned, in the entire State of Wyoming there are only 18 non-federal psychiatrists. Of this number only 12 are within our current catchment area. The availability of mental health services is extremely limited in both the private and public sectors.

Hospital Facilities within
Cheyenne VA Catchment Area

The eight (8) counties in Nebraska have six hospital facilities available. The furthest from Cheyenne is 170 miles--the closest is 60 miles.

The ten counties in Wyoming (excluding Laramie County) have fourteen hospital facilities available. The furthest from Cheyenne is 342 miles--the closest is 49 miles.

WYOMING HOSPITALS IN CHEYENNE VA CACHEMENT AREA

Albany County

Laramie (49 miles)
--1 community hospital
110 beds (99 acute care, 11 long term)

Carbon County

Rawlins (149 miles)
--1 county hospital
99 acute care beds

Converse County

Douglas (129 miles)
--1 county hospital
44 acute care beds

Fremont County

Lander (272 miles)
--1 regional medical center
107 acute care beds
--1 private facility (Pineridge Hospital)
48 acute care beds

Riverton (270 miles)
--1 community hospital
70 acute care beds

Goshen County

Torrington (84 miles)
--1 community hospital
68 beds (53 acute care, 15 swing)

Hot Springs County

Thermopolis (309 miles)
--1 county hospital
49 acute care beds

Johnson County

Buffalo (290 miles)
--1 county hospital
43 beds (29 acute care, 14 swing)

Natrona County

Casper (178 miles)
--1 psych and chemical dependency
54 acute care beds
--1 medical center
282 acute care beds

Platte County

Wheatland (70 miles)
--1 county hospital
172 beds (43 acute care, 43 long term care, 43 swing, 43 nursing home

Washakie County

Worland (342 miles)
--1 county hospital
60 beds (30 acute care, 30 swing)

Fremont County

Ft. Washakie (270 miles)
--1 Indian Health Services (IHS) Outpatient Facility

MENTAL HEALTH CENTERS
Serving Cheyenne VA Catchment Area

Carbon County Counseling Center
Rawlins, WY

Central Wyoming Counseling Center
Casper, WY

East Wyoming Mental Health Center
(Serving Douglas, Lusk and Glenrock, WY

Hot Springs County Counseling Service
Thermopolis, WY

Southeast Mental Health Center
(Serving Cheyenne, Laramie, Torrington and Wheatland, WY)

Washakie Mental Health Services
Worland, WY

NEBRASKA HOSPITALS IN CHEYENNE VA CATCHMENT AREA

Banner County--No facilities

Cheyenne County

Sidney (103 miles)
1--private hospital
131 beds (63 acute care, 69 long term)

Deuel County--No facilities

Garden County

Oshkosh (159 miles)
--1 county hospital
60 beds (20 acute care, 40 convalescent)

Keith County

Ogallala (170 miles)
--1 community hospital
49 acute care beds

Kimball County

Kimball (64 miles)
--1 county hospital
30 acute care beds

Morrill County

Bridgeport (143 miles)
--1 county hospital
23 acute care beds

Scotts Bluff County

Scottsbluff (115 miles)
--1 regional medical center
191 acute care beds
--1 Outpatient Mental Health Center (Panhandle Mental Health)

Medical and Regional
Office Center

2360 East Pershing Blvd.
Cheyenne WY 82001

Department of
Veterans Affairs

December 7, 1989

In Reply Refer to 442/00

Senator Alan Cranston
United States Senate
Committee on Veterans Affairs
Washington, D. C. 20510-6375

Dear Senator Cranston:

This is in reply to your letter dated November 30, 1989, requesting the number of veterans with health insurance who come to VA facilities.

While I cannot speak for all VA facilities, I can tell you what our experience is at the VA Medical Center in Cheyenne, Wyoming. You also need to know that we only have authority to collect this information on our nonservice-connected veterans.

During Fiscal Year 1989, the VA Medical Center in Cheyenne saw 3,546 unique nonservice-connected veterans. Only 303, or 9% of these veterans reported any health insurance. This is an increase over FY 88 in which only 6% of nonservice-connected veterans reported any health insurance coverage. It is difficult to assess whether this trend would continue; however, given the nature of our population and the state of the Wyoming economy, I have no reason to believe it would decrease.

If I can be of further assistance, please let me know.

Sincerely,

GEORGE H. ANDRIES, JR.
Center Director

WRITTEN QUESTIONS FROM CHAIRMAN CRANSTON TO

JIM DEREMO AND THE RESPONSES

1. AS REPRESENTATIVES OF CONSUMERS OF V.A. CARE, WOULD EACH OF YOU SHARE YOUR THOUGHTS REGARDING THE PROBLEMS -- OR SUCCESSES -- VETERANS WHO LIVE IN RURAL AREAS HAVE IN GETTING V.A. HEALTH-CARE SERVICES AND HOW THOSE VETERANS DEAL WITH THOSE PROBLEMS.

1.) One of the major problems many of our veterans have is with the inequity of the Means Test. Many of our veterans are also farmers. And most of these farmers are non service-connected. Because the Means Test provides that anyone with income and/or assets in excess of $40,000.00 (adjusted), many farmers are unable to access VA medical care because they are Category "C" which most VAMC's no longer even let into the system. As Senator Rockefeller pointed out at the hearing, a farmer may have a $100,000.00 in land and has borrowed $100,000.00 against it but may also have a tractor that is paid for. Because his tractor is worth $40,000.00 or more, he is automatically a Category "C" veteran and therefore ineligible for V.A. medical care. This same farmer could, hypothetically sell his tractor, buy a home in town, and then he would be a Category "A" veteran and eligible for medical care.

Access to alternative medical care is not available for many veterans. At the current time many veterans who have been treated by the V.A. for a number of years have now had their care terminated. This includes many Category "A" veterans. And many of these veterans are World War II and Korean veterans, who, because they believed they could always go to the V.A. if they needed health care, did not obtain private health insurance coverage. And now they are at an age where they are having heart attacks, strokes and other serious medical problems requiring extensive medical care. But they can not go to the V.A. and they do not have private health insurance. So they may end up in a private medical facility and having their County pay the bill. The County then places a lien on his assets, and forces him to sell his property to pay for the medical care. Our veterans are outraged by this. Because they had the understanding that they would be able to go to the V.A. if they ever had to, many of our older veterans never purchased private health insurance, in fact many of them never even took out Medicare, because they believed they could use the V.A. When these veterans are unable to access V.A. medical care, they also are unable to access private health care. In rural South Dakota, medical facilities are, in many instances, 200-300 miles away, so they just do not bother going. South Dakota has been able to over come the great distances to the V.A. through the volunteer drivers system. So, if they can be treated at the V.A. they can, in most instances get there.

In summary then it could be said that veterans in our rural area's in many cases can not get treated at the V.A. because of their assets which precludes them because they are Category "C". Those that are eligible for treatment can, for the most part, get to the V.A. Alternative sources of medical care in rural areas are unavailable because of the fact that, hospitals and clinics in rural areas are closed and more are closing all the time.

2. HAVE YOU NOTICED A CHANGE IN THE QUANTITY OR QUALITY OF V.A. HEALTH CARE SERVICES OFFERED IN RECENT YEARS IN YOUR AREAS?

2.) The quality of V.A. health care is absolutely not a problem in the V.A. facilities in South Dakota. Our V.A.'s have some of the best, most dedicated health care professionals in the country, bar none. The provide top notch quality care.

The major problem right now is the quantity. Our doctors, nurses and other direct health care providers are very upset and frustrated with a system that forces them to turn sick patients away without treating them and terminating care to those patients who they have been treating and now may go home, get sick or die, because the V.A. will no longer treat them. And while, at the same time that the V.A. can not find money to treat veterans, it can seem to find money for other "essentials"; like revolving doors, classrooms, fax machines, etc. While these items may be "essential" in the eyes of the administration, in the eyes of our veterans, they are wasteful. So the quantity; i.e. availability and accessibility to the V.A. care over the last several years has declined.

3. WHAT CONSTRAINTS OTHER THAN MONEY ARE THERE TO FULFILLING THE HEALTH-CARE NEEDS OF VETERANS IN YOUR STATE?

3.) Money, of course is the main constraint to fulfilling the health care needs of our veterans. Even the most dedicated doctors can not provide health care without adequate tools of the trade. But the primary constraint now is the accessibility to the medical care. Doctors who have treated a veteran do not want to discharge them because of Administrative judgements, that the veteran, is now "stable" and therefore can be discharged from their care. And then to see this same veteran being hospitalized a few weeks or months later because he quit taking his medication because he could not afford to buy it is extremely disheartening to doctors and other health care providers. Again, the main constraint we see is the doctor's not being able to provide the continuity of care to their patients because of administrative constraints.

4. DO YOU HAVE ANY SUGGESTED SOLUTIONS TO THE PROBLEMS WE HAVE HEARD ABOUT TODAY?

4.) It seems that there is a solution to this current dilemma. First and foremost, it seems that the V.A. as previously stated, is able to find funds for nonessential items. As I said before, in the eyes of our veterans, money is being spent wastefully. With all the committees, subcommittees, oversight committees, etc. it would seem that something needs to be done to ensure that every dollar spent by the V.A. is being spent appropriately. It does not seem to me that it is. In a time of tight fiscal constraints, money is being spent for $40,000.00 revolving doors, $70,000.00 classrooms, new furniture, etc. It just seems that someone needs to "mind the store" a little better.

I would also suggest that a funding mechanism is already in place that would allow the V.A. to be properly funded. But first, Congress needs to address the inadequacy of the "Means Test." In particular the categorization of veterans must be eliminated and the asset criteria for Category "C" must be eliminated. It is unfair to our rural veterans. When a veteran in a town can have a $200.000.00 home and be a Category "A" veteran while a farmer can have $50,000.00 worth of land and be a Category "C" veteran, the system is unfair. So get rid of it!

Those with private health insurance should be charged for their care. The only exception should be is if they are being treated for a service-connected disability. Although most veterans feel that the V.A. should provide free health care, if they have private health insurance, they would not mind having their insurance carrier billed. And in an effort to maintain the ability of each facility to treat veterans any money collected through third party billing should go to the facility that collects it instead of going to the U. S. Treasury as is currently being done. And in conjunction with this, the current V.A. budget needs to be funded appropriately at least at the current levels. So the V.A. budget would come from two sources; first, from third party reimbursement and secondly from general revenues.

This certainly would be a drastic departure from the past when veterans were not charged at all for medical care. However, assuming that Congress and the Administration are either unwilling or unable to make the commitment in dollars to properly and appropriately fund the V.A. so it is able to treat any veteran requiring medical care alternative methods must be found. This proposal is going to require that all veterans make a certain sacrifice for the good of all veterans. That is, those who do have private health insurance, even those service connected veterans, must be willing to have their private health insurance billed for care they receive for any non . service-connected disability so that their fellow veterans who do not have private insurance can receive the care they need.

In conclusion, it seems that three major steps need to be taken to ensure that veterans in rural areas are able to get the medical care they need:

1. Eliminate that portion of the Means Test that categorizes veterans into A, B, and C and disqualifies them from care if their assets exceed $40,000.00.

2. Establish a totally independent watch dog to ensure that funds are being properly spent.

3. Change the current law to allow that all veterans with private health insurance be billed for treatment of any non service-connected disability.

I would like to thank the Committee for allowing me to participate in the discussion of this most serious and vital issue. If I can be of further service I would be more than happy to assist in any way I can.

WRITTEN QUESTIONS FROM CHAIRMAN CRANSTON

TO DR. FRANCIS P. GOLDSTEIN AND THE RESPONSES

1. What is the breakdown of service-connected and nonservice-connected veterans in your catchment area?

Our catchment area is 55.5 percent service-connected and 44.5% nonservice-connected. These figures are derived from the percentage of patients treated at our facility through the third quarter of FY 89. We do not have available similar data on veterans who do not seek VA health care.

2. What non-VA resources are available to the geographically hard-to-serve veterans in your catchment area, especially to those veterans who are furthest away from a VA facility?

This question is dealt with extensively in my written testimony to which I make reference. South Carolina is a medically under-served area. Known VA resources are not abundant, especially outside of large cities.

County of El Paso

JIM NIER
DIRECTOR

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4824 ALBERTA AVE. SUITE 342
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HELEN A. RUIZ
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November 27, 1989

The Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Following are the VFW's responses to questions that time did not allow being asked at the November 15, 1989, Senate Veterans' Affairs Committee hearing on rural health care.

With best wishes and kind regards,

Sincerely,

James E. Nier

JAMES E. NIER, Director
Veterans Assistance Office

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QUESTION #2: Have you noticed a change in the quantity or quality of VA health-care services offered in recent years in your areas?

RESPONSE #2: While I have not seen a deterioration in the quality of VA health-care services offered in recent years, it is very obvious to me VA health-care professionals are under much pressure to maintain that quality of service. With respect to quantity, I have noticed the VA cannot supply care to all veterans who desire it.

QUESTION #3: What constraints -- other than money -- are there to fulfilling the health-care needs of veterans in your state?

RESPONSE #3: Again, the biggest constraint veterans face is traveling the great distances to VA medical centers. If a veteran does not have access to private transportation, he is virtually locked out of the system.

QUESTION #4: Do you have any suggested solutions to the problems we have heard about today?

RESPONSE #4:

(a) More mobile health-care screening units are needed. This would enable VA to provide health care to a larger number of veterans living in isolated rural areas. The primary mission of such screening units would be diagnostic but they would also provide for basic health care needs.

(b) Hospital based home care units should be increased in number and their operating area should also be increased. Currently, the few such units that do exist only provide service within a 30-mile radius. This form of care allows the veteran patient to remain at home with his family and, therefore, is both highly cost effective and compassionate.

(c) Public health nurses (visitor nurses) should be provided by the VA. Public health nurses are able to provide screening and tend to the basic health-care needs of a large number of veteran patients living in isolated rural areas in an effective manner and at relatively low cost.

(d) VA could send health care screening teams to VFW and other veteran organization's Post Homes. For our part, VFW Post Homes in rural areas would welcome the opportunity to make their premises available to provide health care to veterans. Doctors and nurses could utilize vans and station wagons to reach rural areas. This way they would not have to rely on expensive mobile trailors and RVs since the Post Home would be providing them with the necessary physical plant t conduct their exams. The health care needs of rural veterans would be well-served for a relatively few dollars.

(e) Finally, the VA may want to consider supplying some form of lodging to veterans who have to travel extended distances for health care. I would not suggest that veterans ever be denied health care because a bed is being occupied on a "lodging" basis. But, if a separate area could be established for a "dorm" type purpose, veterans and those supplying the veteran's transportation may be more willing to travel those great distances.

THE AMERICAN LEGION OF MONTANA ★ P.O. BOX 6075 ★ HELENA, MONTANA 59604
VETERANS AND PIONEERS MEMORIAL BUILDING ★ (406) 442-5260 ★ *SERVING GOD AND COUNTRY*

November 17, 1989

Honorable Alan Cranston
United States Senate
Chairman, Committee for
Veterans Affairs
112 Hart Office Building
Washington, D. C. 20510

Dear Senator Cranston:

Before I address the questions provided by Senator Rockefeller of your Committee on the recent hearing for veterans health care in rural areas, I would like to express my sincere appreciation for the opportunity to appear before your Committee on November 15, 1989.

I would like to address each question individually and respond accordingly.

Question; As representatives of consumers of VA care, would each of you share your thoughts regarding problems -- or success -- veterans who live in rural areas have in getting VA health care services and how those veterans deal with those problems ?

Answer: Other than funding, which we all have a concern about, the major problems facing rural veterans can be isolated into two categories:

1. The need for qualified medical personnel in the rural VA hospitals. Recruitment and retention of qualified personnel has been, and will probably continue to be a problem unless some concessions are made to attract and retain qualified medical personnel in the rural VA hospital environment.

   Specifically, I would suggest considerations be given to incentive bonuses for contract placement of medical personnel (perhaps a two or three year contract), along with a similar plan for retention for contract renewal, moving allowances or relocation gratuities, and R & R periods, etc. for those medical personnel in the rural VA hospitals.

2. Accessibility to the VA hospital or clinic for treatment continues to be a major problem in rural VA hospitals, both for the hospital and the veteran. Suggestions for mobile clinics may solve part of the problem in the sub-urban areas. Mobile clinics in the rural areas however, may add to the problem more than the solution. Any special type of medical work-up (x-ray, lab, ekg, etc..) will still require the veteran patient to be in the hospital as an inpatient or outpatient, or will require transporting of special equipment along with the mobile clinic. In addition, mobile clinics must be manned by qualified medical personnel (M. D.'s & R. N.'s) which will decrease the medical staff at the hospital during the tour of the mobile clinic.

Medical personnel would be required to drive long distances from the hospital to outlying communities to service the veterans, perhaps only a few in number, before departing for the next community. the time in transport could be put to better use if medical personnel treated patients in the hospital or clinic.

It has always been my contention that it would be extremely difficult in a large, remote, rural area, to take the hospital to the veteran, whereas getting the veteran to the hospital can be accomplished with a coordinated effort.

It is my suggestion that rural VA hospitals establish a cooperative, cohesive arrangement with the veterans service organizations within the "Primary Service Area" of the VA hospital to provide transportation and volunteers to drive vehicles providing direct access to the VA hospital.

Where distances require an overnight stay at the VA hospital, the veterans could simply be "lodged" for the night along with the volunteer driver and return the following day.

Question: Have you noticed a change in the quantity or quality of VA health care services offered in recent years in your area ?

Answer: Absolutely yes -- without question. In November, 1986, the Miles City VAMC received a new hospital director, James A. Huff. With his administrative leadership, employee morale increased along with production. Mr. Huff recruited a highly qualified medical chief of staff and put pride in accomplishment back into a degenerated environment.

If the quality andor quantity of medical service, including employee and patient morale are below a satisfactory level, the solution may rest in a personnel management area. Underpaid and understaffed medical centers within the VA place a heavy demand on those employed. Leadership under these circumstances becomes extremely important to maintain morale. The proof in this scenario has been the elevation of Miles City VAMC from an extremely low grade to one of the most cost effective, qualitative and quantitative hospitals in the entire VA system.

Question: What constraints -- other than money -- are there to fulfilling the health care needs of veterans in your state ?

Answer: The two most problematic constarints that affect rural VA hospitals have been addressed -- transportation -- and -- qualified medical people to man the facility. One must also include management leadership, or rather, the lack of it as a constraint to health care. A qualified, concerned, and caring medical director is imperative to the success of any VA hospital. Poor management practices may well affect the confidence a veteran has in medical care available. VA medical centers should exercise a positive public relations attitude toward the veteran population -- keep them informed -- let them know they care -- coordinate with veterans service organizations on problems -- solutions and needed assistance where finances can not be received through budget allocations.

Question: Do you have any suggested solutions to the problems we have heard today ?

Answer: It is difficult for me to challenge the statements of other witnesses that appeared, however, I do take exception to those remarks which cast a cloud of callous treatment of veterans by the VA medical personnel. Overall, I have found nothing but caring, compassionate, dedicated medical, administrative, and support personnel within the entire VA medical system. Any reference to a con-caring, insensitive, verbal abuse, etc.. must be in extremely isolated cases. I cannot believe that this type of treatment is inherent in rural VA hospitals, or for that matter, in urban hospitals. If such be the case, these problems should be addressed and corrected through a formal complaint to the hospital director and/or medical chief of staff for corrective action.

In view of the shortfalls in the budget over recent years in the VA, only a highly dedicated, caring, and compassionate medical staff could have kept pace with quality care with fewer and fewer dollars. We should be commending -- not criticizing VA medical personnel for an outstanding job well done under the worst of conditions.

Transportation of veterans appears to be a universal problem from all witnesses. As veterans, we must appreciate the problems facing this Country through our massive deficit, and attempt to contribute our share to its demise. To expect the government to provide an elaborate transportation system nationwide for veterans access to VA hospitals would be impossible to achieve.

We cannot, however disregard that the problems exists and is vital to providing health care to veterans in rural areas. The Miles City VAMC has made great strides in the area of transportation.

I suggest that with proper utilization of present on-site vehicles, and establishment of a cooperative, cohesive relationship between the VAMC's and the veterans service organizations in the primary service areas, the problem of transportation can be greatly minimized or eliminated through donated vehicles and volunteer drivers.

The Miles City VAMC is a shining example of just what can be accomplished through a joint effort between VA management and staff, community, and veterans service organizations.

In closing, again please accept my appreciation for the opportunity to express the concerns of veterans in the State of Montana. We must have the funding necessary to provide quality medical care to an aging veteran population -- we must assume the responsibility to inform a veteran population of their "earned entitlements" through their active military service. An informed veteran can offer assistance to problems as they arise -- an ignorant veteran can only make waves -- complain -- write to his congressman and senator -- write letters to the editor, etc.. IT IS MUCH EASIER TO HAVE AN INFORMED VETERAN PUBLIC.

Please continue your study on rural health care for our veterans. Your concerns and those of other Committee members is greatly appreciated.

Sincerely,

Raymond L. Seerup

RAYMOND L. SEERUP
Department Commander
American Legion of Montana
2835 Oakland Drive
Billings, Montana 59102

cc: Senator Rockefeller
Secretary Derwinski
Nat'l Hq., American Legion

WRITTEN QUESTIONS FROM CHAIRMAN CRANSTON TO
JOHN WOODS AND THE RESPONSES

Health Care for Rural Veterans

I wish to express my sincere appreciation for this opportunity to address the issues concerning rural veterans. As a nationally accredited Service Representative for Vietnam Veterans of America, Inc., my primary duty falls in the legal preparation, presentation and prosecution of claims before the United States Department of Veterans' Affairs. Also, I currently direct a full service delivery program within the State of Texas for the Vietnam Veterans Resource and Service Center, Incorporated.
With these credentials, may I present the following testimony in good faith, as I believe each point expressed to be true, and based on my personal exposure and professional observations of significant matters pertaining directly to rural community veterans and certain minority veterans.

Question #1: As Representatives of consumers of VA care, would each of you share your thoughts regarding the problems -- or successes -- veterans who live in rural areas have in getting VA health care services and how those veterans deal with those problems.

Response: Rural community veterans face many significant problems during the individual course of seeking adequate professional health care through the United States Department

of Veterans' Affairs. Although the system is, based on theory, designed to meet the needs of veterans, functional aspects can easily be identified which clearly demonstrate a different reality of unnecessary burden for rural veterans actively seeking health care benefits. One of the initial problematic areas confronting this peer group is found, and should be recognized, in simply seeking health care. An immediate financial burden is placed on the rural veteran when he must take time from employment, thus losing wages, and further endure financial burden to travel many miles in distance to reach a VA facility. If this trip is not a VA requested scheduled appointment for a service connected, previously approved disability, there exists no financial program to assist in alleviating the financial burden which, in fact, may normally include situations which may prove a clear service connected disability.

Regardless of whether it may later be determined as a service connected disability, with or without compensation, the rural veteran never receives reimbursements for any/all VA deemed necessary medical appointments which are necessary in complete evaluation of disability determination.

After arrival and completion of the standard intake registration, triage, the veteran often is left waiting 2 to 5 hours or more before actually being seen by a physician. The attending physician then makes a determination as to whether the reported illness warrants immediate medical treatment. After incurring the travel expense burden and

waiting an excessive period of time, the rural veteran is often told that he/she will not be allowed medical treatment for the ailment which prompted him/her to implore the VA for medical care in the first place. I do acknowledge that exceptions do exist, for instance, emergency status or physician's determination as an immediate health care priority. However, examples also exist where, after making the long journey for seemingly nothing, the veteran will return to his/her rural community, file a disability claim, only to eventually receive formal notification from the VA Regional Office that his/her claim was denied based on lack of supporting evidence. Then, should the veteran appeal the decision of denial, and actually file an appeal, actual case histories would demonstrate that it may take 8 to 10 months before the VA authorizes an evaluation appointment which would provide supporting evidence of service connection. The time span between the initial application for medical treatment, the denial, the Regional Office claim application by the rural veteran, that denial, and the appeal process leading to the actual medical evaluation could be excessive, negligent, and could very easily allow time for deterioration of the disorder which may be irreversible when the rural veteran finally receives proper medical treatment. Circumstances such as these normally result with the veterans' disgust and decision not to return to the VA facility until such time as they feel to be in a critical state of health.

Similar, if not more unique problems face the ethnic minority veteran peer group, such as the Native American veteran who reside within their cultural peer group community sometimes found to be remote, such as reservations or isolated townships. Reference to this category can be found in the Veterans Administration Advisory Committee on Native American Veterans, dated February 1, 1989. In supplement to this published report, I would submit that I have no knowledge of an adequate outreach program presently in existence by the VA to provide medical services for these special minorities, nor a health treatment program for their possible service connected disabilities which were acquired during active duty participation for this country's armed military forces.

In regard to the mental health care issue, current legislation before the U.S. Congress clearly suggests that over 800,000 Vietnam Era Veterans may suffer from Post Traumatic Stress Disorder (PTSD) and yet only 10% of those in need of adequate treatment are actually receiving mental health care (RTI study). Some of the common symptoms normally found with PTSD include, but are not limited to, depression, isolation, alienation and basic feelings of rejection. Far too many times the individual with PTSD will come to the realization that he has failed to leave the shadow of his Vietnam War experience to come into the light of a normal productive lifestyle within mainstream society and he/she will seek consultation from the Veterans Administration. As he faces some of the functional realities

here so described, many times a very negative effect is found which complicates his PTSD symptoms and can even become damaging. Previously recognizing this, the VA developed and deployed the storefront Vet Center program, however this program historically has appeared doomed for extinction due to budget cuts. For the rural community veteran, a simple weekly trip to a Vet Center, because of that may a great distance, is found financially far too big a burden. Private sector mental health care contracts which could effectively provide mental health care services to rural areas, are normally the first item cut during a budget squeeze, and rural veterans are disproportionately hurt. A more secure financially supported readjustment counselling private sector contract program must be developed to meet the rural community veteran's mental health needs. Limitations should be lifted by the VA to include an assertive outreach readjustment program which would include incarcerated veterans with PTSD symptoms. This would greatly enhance rehabilitation and successful reintegration upon release as a "productive member" of today's society.

Other issues that occur which have very adverse effects of rural veterans include; medical school affiliations, services for female veterans, the special ambulatory program and relocation of services by the VA.

In conclusion, based on the differences found between the VA's theory and design for delivering adequate health care services and the reality of functional performance which

creates very negative results for the rural community veteran and certain minority veterans, I feel it parliament and essential to identify the enormous need for veterans to be accepted into the decision making coalition, where the process is found relative to the delivery of VA health care. Who would know more than those veterans that have actually faced the differences between design theory and functional delivery, how to recommend productive alternatives. When the veteran's health care is at question, the veteran's contribution of answers can only be found productive.

Question #2: Have you noticed a change in the quantity or quality of VA Health-Care Services offered in recent years in your area?

Response: Quantity of Health-Care Services would seem to have been increased in recent years only as a direct result of a larger number of veterans actively seeking medical assistance, not as a direct result of the VA's successful or willful expansion of such services. Actual numbers of applying veterans have shown a significant increase in quantity in services provided by the VA, however, this increase has created a burden of responsibility for the VA and in many ways it can be clearly identified as adversely effecting the quality of individual health care.
Quality, again, has in many cases seemed adversely effected by the vast quantity of those seeking health care services

from the VA, however, I do conclude that at the same time modern medical technology has in many areas of health care delivery, especially in diagnostic and surgical procedures, been improved.

Because of the quantity of those in need of VA services, reaching the quality available through modern technology becomes very time consuming for the individual veteran at all times except very extreme medical emergency situations.

Question #3: What constraints -- other than money -- are there to fulfilling the Health-Care need of veterans in your state?

Response: One of the major constraints facing specifically the largest concentration of veterans within the state of Texas, other than the all too obvious lack of actual numbers in VA facilities to provide health care services, can clearly be fund in the reduction of work-force personnel, especially within the VA Regional Offices. for example, VVA's Service Program has found that the largest concentration of veterans (both Vietnam era veterans and other generational veterans) seeking health care services over the last 3 year period reside in the northern, central and eastern regions of our state. This places an administrative burden under the jurisdiction of the VA Regional Offices located in Waco, Texas. While a growing, larger number of veterans are seeking health care services are, by regulation, currently

having claims processed through the Waco Regional Offices, during the last 3 years the work force personnel has been reduced in actual number. This reduction of VA personnel, combined with the obvious increase of veterans seeking health care service who process legitimate service connected disability claims through that office of the VA, has created a horrendous burden to both VA personnel and the individual veteran. Three years ago, a veteran could file a service connected disability claim for services through the Waco VA Regional Offices and actually receive a response pertaining to the determination within 45 to 60 days, however, current evidence demonstrates this same procedure now can be expected to take between 120 to 180 days, and complicated cased have been found to actually even at times take even longer. There can only be suggestion presented, in recognizing this situation, that some negligence may take place during the VA administrative processing of legitimate service connected disability claims, therefore hurting in many ways each individual veteran who seeks appropriate health care services.

Also, this time period, I reiterate, may easily allow further deterioration of the particular service connected disabling disorder which may be found irreversible.

Question #4: Do you have any suggested solutions to the problems we have heard about today?

Response: An increase in VA Medical Facilities, an increase in VA Regional Office personnel to adequately maintain administrative processing of claims in a responsible, effective and "timely" manner, and an expansion on private sector contracting programs to provide medical and mental health services to rural area veterans would only present the "beginning" of a productive solution to the problem. Other solutions have been respectfully suggested throughout my response to Question #1 of this statement, as well as previously presented by myself for the Vietnam Veterans of America during oral testimony on November 15, 1989 to the Senate Veterans Affairs Committee. In conclusion, may I state that it has been an honor to provide both oral testimony to the committee and formal response to the Honorable Senator Rockefeller's questioning, and I would greatly appreciate future opportunities to provide personal service or input to this Senate Veterans Affairs Committee regarding this very complicated issue, on behalf of the Vietnam Veterans of America, Inc.

Thank you.

Sincerely,

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WRITTEN QUESTIONS FROM SENATOR BURDICK TO

THE DEPARTMENT OF VETERANS AFFAIRS AND THE RESPONSES

Question 1: What is the intention of the Department of Veterans Affairs regarding the Fargo regional office?

Answer: During the past 15 years VBA staffing has declined from 20,000 to 12,600. Through increased automation we are able to provide an improved level of services at all sites.

Economic and social changes have causes a considerable shift in the veteran population and a corresponding shift in regional office workload patterns throughout the nation. These workload changes, in combination with limited availability of resources, compelled us to examine a number of alternatives which would enable us to maintain existing levels of service to veterans in all areas and which also show potential for improved quality and efficiency in benefits delivery. Effective delivery of benefits into the future requires that we assess both the needs of the veteran population which we expect to decline and to age, and the organization of our field and Central Office structure.

One such alternative under consideration provides for the reassignment of management responsibility for operating divisions in our smaller regional offices, such as Fargo, to larger regional offices, thereby maximizing the resources which can be devoted to direct labor functions. While we have no current plans to reassign functions, we must continue to examine such alternatives and to seek ways in which we can provide the best possible services with the fewest resources. All employees affected by any future organization changes will be offered the opportunity to move or be placed in a local office.

Question 2: Are there any plans, in the long term or the short term, to close this office or make any substantive changes in its mission?

Answer: There are no long or short term plans to close the Fargo regional office. The proposal your letter addresses concerns only the actual claims processing activity and would not require claimants to travel to another regional office to obtain VA services. We have made no proposals that would affect direct veteran access to the regional offices. Consolidation of the adjudication function would in no way reduce claims processing operating costs. These savings would be available for increased outreach and other activities which would improve the access of veterans to VA services.

Question 3: Is there a plan to include funds for any consolidation of the type mentioned in the memo in the VA's budget request for any year in the next five-year period?

Answer: We are in the preliminary planning and review phase concerning field station organization. No decisions have been made. While there is no current plan to request funds for consolidation this would change if it is determined that the consolidation of operating divisions is in the best interest of the Department and the veterans we serve. It is possible that such a request could be made in the next five years. VA is required by law to provide notification to Congress prior to any consolidation of VA operations resulting in the reduction of 10% of the employees at a facility which employs more than 25 full-time employees. At the same time, we would also have to provide a detailed plan and justification of the proposed consolidation.

WRITTEN QUESTIONS FROM SENATOR MURKOWSKI TO

GEORGE ANDRIES AND THE RESPONSES

Question: 1. Does VA define its facilities as rural or urban? If so, is your VA facility considered by VA officials as rural? Would such a classification be useful?

Answer: At the present time, the VA does not classify facilities as rural or urban. Under the Resource Allocation Model, hospitals are grouped by a number of factors including bed size, outpatient workload and affiliation status. Developing such a rural or urban classification would only be useful if it were based upon the specific problems encountered by rural or urban hospitals and served as a basis for identifying the type of resources needed to provide appropriate levels of health care at either type of facility.

Question: 2. How has your facility been treated under VA's Resource Allocation Methodology? Do you believe that rural hospitals fare worse in VA's resource process?

Answer This facility has been treated the same as other similar facilities under the VA's Resource Allocation Methodology.

This does not mean the system is flawless. One of the major problems with the Resource Allocation Methodology for the last several fiscal years as far as small non-affiliated hospitals is concerned, has been the introduction of hospital groupings. Conceptually, the groupings were to restrict the competition for resources between hospitals of similar size and missions. Thus, small, non-affiliated hospitals were to compete on a basis of productivity with other similar-size hospitals. In theory, budget resources were not to move between groups. In practice, however, there has been a net loss of over $4,700,000 from the small, non-affiliated group as a whole for the last three fiscal years. Given the small size of these Centers' budgets, in relation to large Medical Centers, the net affect of these losses has been magnified. Consequently, the amount of resources available to the small, non-affiliated Center has been reduced significantly.

Question: 3. Did your facility generally have to pay more veterans for travel expenses than urban facilities? If so, do you receive an additional allocation for beneficiary travel?

Answer: We do pay more for travel than urban facilities because of the distances involved and our lack of public transportation. However, this difference in travel patterns appears to be reflected not only in our historical expenditures but also in our current budget.

Question: 4. Could you explain any difficulties with recruitment and retention of personnel that you may be experiencing?

Answer: The major recruiting problem we have is for physicians. The reason is simple. Our current physician salaries are not competitive with those available in private practice. At the present time, we are not even competitive with the salaries being paid to military physicians. For example, a Major with ten years active duty who is a board-certified general surgeon, would receive total annual compensation in 1990 amounting to over $109,000, which includes non-contributatory health and life insurance. On the other hand, the best we can offer the same board-certified general surgeon with the current bonus is $87,703 and a portion of the cost of his health and life insurance.

Because our Center is not affiliated with a medical school, we have neither the resources of our affiliate medical school to augment salaries nor their reputation nor their lure of academic stimulation or research capability to attract physicians and to offset the salary differential that exists between our current physician pay level and those that exist in the private sector and in the military. Finally, even though the Cheyenne VA Center is relatively close to larger urban centers such as Denver or Ft. Collins, it is seen as a remote assignment not only to the physician applicants but, more importantly, to their family members.

We cannot do anything to change the remote perception of the Cheyenne VA Center except to provide funds to bring both the physician applicant and his family out to see the area so that they can make an informed decision. Currently, we have no funds available to bring spouses out. Moreover, funds to bring physician applicants out for interview are insufficient at best.

As far as salary is concerned, the overall amount of salary must be increased. As far as the rural non-affiliated centers are concerned, there must be some sort of adjustment that takes into effect the lack of the affiliation resources both tangible and intangible that do not exist. The relationship between salary and recruitment ability is exemplified by the fact that the Cheyenne VA Center, unlike most VA facilities, has been for many years a magnet hospital for recruiting nurses, primarily because our salary levels were competitive and even slightly higher than the private sector. In the case of medical care professionals, we must be salary competitive within the marketplace, if we are to attract competent personnel.

Question: 5. Do you have ideas for expanding access or quality of services for veterans in rural areas that you are not able to implement due to lack of resources or legislative authority? Could you please explain those ideas.

Answer: As I indicated in my testimony, the most effective way of expanding veteran access to health care and for maintaining the quality of service which we offer, is through the establishment of small, stationary, rural outreach clinics. Strategically locating these small outreach clinics in juxtaposition to existing community health care facilities would provide necessary emergency facilities, and lower the fixed operational costs of the facilities. Locating these facilities within 100 miles of the veteran population served, would increase the ease of access to the veterans who are eligible for care.

Though these rural outreach clinics, by nature of their size, could not provide a full range of health care services, they could very effectively provide primary health care services, serve as referral points for veterans to more advanced VA health care facilities, and, finally, provide convenient follow-up for the veterans once the more advanced health care services have been provided.

As far as mental health services are concerned, the question of distance and the availability of trained personnel are the primary issues. If it is possible to recruit appropriate mental health workers, it would be extremely appropriate to add a mental health component to the rural outreach clinics. Absent these types of personnel, it would be appropriate to work with existing state and county mental health services to provide treatment for eligible veterans. In this case, however, it would be necessary to provide these community resources with effective continuing training concerning specialty areas such as PTSD. Moreover, because of the nature of mental illness, I believe it would be useful to utilize the existing Dental Treatment Model whereby individual treatment plans are developed for each veteran, reviewed and approved by a qualified VA facility and then periodically monitored for effectiveness.

As I indicated in my testimony, the MEDIPP process has identified the Casper area because of its size as the first site for such a Rural Outreach Clinic in Wyoming. In addition, our own local planning process has determined that if additional Rural Outreach Clinics were located in the Scottsbluff and Riverton-Lander areas, all veterans in our catchment area would be within approximately 100 miles of a VA facility.

This particular proposal has not been reviewed at higher level yet.

Question: 6. In your opinion, is VA adequately handling the health care needs of the rural veteran population? If not, how can VA improve?

Answer It is my opinion that the VA is providing good health care to those veterans in rural areas who can access our existing health care facilities. The main issue, therefore, is relative ease of access. All studies indicate that the utilization of VA facilities declines dramatically if the veteran must travel over 100 miles. As I indicated in my testimony, our experience during the last several fiscal years bears this fact out. Since over 50% of the area within our catchment area is over 100 miles from any VA care facility, the adequacy of health care which we provide is limited.

As noted above, the most cost-effective way of improving the adequacy of this care is with the establishment of small, rural Outreach Clinics that are strategically located.

WRITTEN QUESTIONS FROM SENATOR MURKOWSKI TO

THE DEPARTMENT OF VETERANS AFFAIRS AND THE RESPONSES

Question: 1. What percentage of the veteran population lives in rural areas?

Answer: The 1985 Veterans' Health Care Act (Section 202 of P.L. 98-528) required two reports on health care for veterans living in remote areas. In both reports, VA operationally defined "rural" as any veteran living more than 100 miles from a VA medical facility. In the first report, "Study of Health Care Services to Veterans Living in Geographically Remote Areas", submitted to Congress in February, 1986, VA estimated that only three percent of 28 million veterans resided more than 100 miles from a VA medical facility.

Over the last four years, VA has added 21 community-based clinics (CBC), 111 outreach clinics and 5 new satellite clinics. VA planning criteria and standards for establishing new clinics encourage new satellite clinics to be established 75 or more miles from a VA Medical Center (VAMC), while community-based clinics should be located 100 or more miles from a VA medical center (three are 200 miles or more). With a few exceptions, outreach clinics are generally conducted within 100 miles of a VA facility, since the major form of outreach is a mobile team and the convenience and economies of staff travel from the home base VA medical center must be considered. We have not conducted another survey since 1985, but the number of veterans living more than 100 miles from a VA facility should be less than in 1985, given the addition of several new outpatient clinics since that year.

Question: 2. What percentage of rural veterans use VA's medical care system? How does this percentage compare with veterans who live in urban areas?

Answer: In the report, "Study of Health Care Services to Veterans Living in Geographically Remote Areas," distance from a medical facility was found to be the most significant factor affecting VA health care utilization. The utilization rates for a veteran living in a geographically remote area was relatively the same as for a veteran living in an urban area, if both lived an equal distance from a VA facility. According to the study, the number of veterans who use VA outpatient services drops from 90 per 1000 within 25 miles of a VA facility to 62 per 1000 at a distance of 50 miles, followed by a gradual decline as distance increases.

Recent examples from newly established outpatient clinics suggest that additional factors might have a significant impact on utilization of VA outpatient clinics. For example, actual utilization rates at the community-based clinics in Farmington, NM, and Redding, CA, are two and three times higher than originally projected. Projected utilization rates were based primarily on the distance criteria established in the 1985 study. The Farmington and Redding clinics were chosen as two pilot demonstrations during FY 1987 as the most promising alternatives for improving access to care. A final evaluation of both clinics will be completed and provided to Congress this year.

Question: 3. The ability to benefit from VA's medical care system has always depended on the veterans' ability to go to a VA facility. With that in mind, is VA meeting its obligation to provide care to rural veterans?

Answer: There remain some areas of underservice, and as we become more aware of these, innovative programs can be deployed to address specific problem areas.

The 1985 VA study identified 84 counties as so remote from VA medical centers, that alternative care arrangements needed to be considered for veterans living in these areas. Several of the locations have been selected through regional planning and 137 clinics have been activated since that study was done.

A July 1988 survey of outpatient services provided at locations away from medical centers indicated the necessity of carefully evaluating and monitoring the cost-effectiveness of locating an outpatient clinic long distances from a VA medical center. Locating a small clinic 100-300 miles from a medical center presents several challenges. Continuing medical education, communication, supervision, and, travel time often required by medical staff, become problematic. Secondly, a small clinic with minimal services cannot provide the quality of care available in a full satellite clinic, or a community hospital.

Improving access to VA health care for veterans in geographically remote areas must include the full range of health delivery mechanisms available to VA, including VA-DoD shared services, and VA fee-basis care with community providers. In some cases it might be more cost-effective to arrange local transportation networks to the nearest VA facility.

Question: 4. Does it cost more to provide care through facilities located in rural areas? What type of information do you have to support that conclusion?

Answer: Satellite, community-based and outreach clinics are not administratively separate from their parent medical centers. Currently there is no centralized cost of operation reporting system that would allow VA to routinely compare the cost of operations between these outpatient activities and outpatient care provided by a medical center. This reporting mechanism is not satisfactory, but modifications to the mechanism are planned to take effect in FY 1991.

The 1988 survey of outpatient activities held away from VA medical centers, did indicate that a large majority (83 percent) of the clinics were able to separate costs from their parent facility and provide a separate report upon request. In FY 1987 the average cost per visit for Satellite, community-based and Outreach Program were as follows:

Satellite	$80.30
Community-based	81.60
Outreach Program	24.30

In comparison, the FY 1987 average cost per outpatient visit in a VAMC or under Fee-basis care were as follows:

VAMC	$ 86.64
Fee-basis	143.69

The demonstration projects at Farmington, NM, and Redding, CA, are being evaluated in terms of improving access to health care, the quality and cost of services, satisfaction of veterans, and staff morale. The evaluation is being conducted by the Far West HSR&D Field Program. The completion date is anticipated to be April 1990.

Question: 5. Overall, does VA have difficulty recruiting and retaining personnel in rural VA facilities? How do their problems differ from urban hospitals?

Answer: In general, urban VA medical centers which provide comprehensive medical care typically encounter a shortage of personnel, or the lack of a particular medical specialty, like orthopedic or cardiac surgery. In contrast, clinics in remote geoqraphical areas provide less specialty services and provide more coordinated primary care.

Shortfalls in recruiting for rural facilities tend to be in the general medical fields. Three rural clinics, for example, in New Mexico are having difficulty hiring general internists. This problem is exacerbated by the inability tc hire support staff, including nurses. Physicians in the area prefer to work in urban HMO's that offer higher salaries, similar work hours, less travel time, and adequate staff support.

Question: 6. Do you have any suggestions on how VA can work with other government agencies and the private sector to increase access and minimize health care costs in rural areas?

Answer: In the southwest and Alaska, there should be opportunities to coordinate veterans health care services with existing Indian Health Service clinics. The rural health program in New Mexico is currently developing such opportunities in Taos and Gallop, NM. In Farmington, NM, VA staff work with the Presbyterian Medical Services and contract with them for space, laboratory, radiology and physician services.

The Redding, CA, Clinic uses a donated van and drivers from a local Disabled American Veterans (DAV) chapter to transport veterans who need specialty medical care from the clinic to the VAMC in Martinez, CA. A DAV chapter in Miles City MT, operates a van for veterans between Miles City and the VAMC at Fort Harrison, MT.

WRITTEN QUESTIONS FROM SENATOR MURKOWSKI

TO DR. FRANCIS P. GOLDSTEIN AND THE RESPONSES

1a. Does VA define its facilities as rural or urban?

No - the DVA defines their facilities by type, i.e. GM&S (General Medical and Surgical), Psychiatric, Satellite or Independent Outpatient Clinic.

1b. If so, is your VA facility considered by VA officials as rural?

Not applicable.

1c. Would such a classification be useful?

I do not believe classification as rural or urban would serve any useful purpose, since most facilities have catchment areas which encompass both types of regions.

2a. How has your facility been treated under VA's resource allocation methodology?

Under the Resource Allocation Methodology DVA facilities were separated into six groupings which took into account the size and missions of the facilities. Reimbursement to facilities under the RAM were dependent on data input of both inpatients and outpatients along with certain special services.

2b. Do you believe that rural hospitals fare worse in VA's resource process?

Since reimbursement was based on this data input and in comparison to other facilities of similar size and mission we believe we were treated fairly. Because the DVA defines its facilities based on size and mission we do not feel "rural" facilities fare any worse than "urban" facilities.

3a. Did your facility generally have to pay more veterans for travel expenses than urban facilities?

We are unable to honestly answer this question since data is not available with respect to the number of travel payments made by individual facilities, and the DVA does not define its facilities in terms of rural vs. urban.

3b. If so, do you receive an additional allocation for beneficiary travel?

Supplemental funding was distributed to all DVA facilities for the Beneficiary Travel Program late in FY 88 after mileage payments were reinstituted. FY 89 funding for this program was based on each facility's budget projections for the year.

4. Could you each explain any difficulties with recruitment a retention o' personnel that you may be experiencing?

While resource restraints have not caused difficulty in filling vital personnel positions, the inability of GS and Title 38 pay scales to keep pace with salaries in the private sector along with the relative scarcity of available candidates for physician, nursing, pharmacy, and other allied health positions are the reasons for recruitment and retention difficulties.

5a. Do you have any ideas for expanding access or quality of services for veterans in rural areas that you are not able to implement due to lack of resources or legislative authority?

This question is answered in the written testimony which I submitted to the Committee at the time of my appearance.

5b. Could you please explain those ideas.

This question is answered in the written testimony which I submitted to the Committee at the time of my appearance.

6a. In your opinion, is VA adequately handling the health care needs of the rural veteran population?

This question is answered in the written testimony which I submitted to the Committee at the time of my appearance.

6b. If not, how can VA improve?

This question is answered in the written testimony which I submitted to the Committee at the time of my appearance.

WRITTEN QUESTIONS FROM SENATOR SIMPSON TO

GEORGE ANDRIES AND THE RESPONSES

Question: 1. What are the biggest problems facing the veterans who are in the primary service areas of the Cheyenne and Sheridan VA Medical Centers in terms of access to VA health care?

Answer: As I noted in my testimony, the major problems that veterans in the Cheyenne and Sheridan VA primary service areas face are distance and the lack of a convenient public transportation system.

Casper, Wyoming, which is the second largest city in the State of Wyoming, is approximately 175 miles from either Cheyenne or Sheridan. Veterans must drive, utilizing their own private vehicles, approximately three hours to reach either VA health care facility in the state. Although the DAV has provided vans, the driving distance remains the same. Consequently, veterans in Casper are looking at approximately six hours of transportation time, if they wish to access VA health care facilities at either Sheridan or Cheyenne.

Veterans in the Scottsbluff, Nebraska area, which is approximately 120 miles from Cheyenne, face approximately four hours of driving time to access the Cheyenne VA Center for outpatient treatment. Given the increasing age of our veteran population, distances such as this make utilization of our existing facility difficult.

In addition to the problems distance cause our individual veterans, distance and the lack of convenient air travel make it difficult for the two Wyoming VA Centers to support one another's basic missions. One of the Sheridan VA's primary missions is to provide long-term psychiatric care. On the other hand, the Cheyenne VA Center is to provide surgical support for the patients in the Sheridan catchment area. The direct air service which used to exist between Sheridan and Cheyenne has been eliminated. Consequently, patients being transported between the two facilities must either be driven or placed on planes which leave the State of Wyoming. In this latter case, existing commercial flights not only leave the State of Wyoming, but begin or terminate in Denver. Thus, the patient must then be transported an additional 120 miles by ground transportation to and from the Cheyenne VA Center. As anyone who has used Stapleton Airport in Denver knows, it is difficult for healthy people to navigate this airport, much less patients requiring surgery or long-term psychiatric care.

Question: 2. Have you pursued the possibility of working out an arrangement with the Air Force to transport patients between medical centers in a way that would be cost-effective for the VA and efficient and safe for the patients?

Answer: We have met with the Air Force Air-Evac System. Current regulations allow us to utilize this system for our patients. Despite the fact that the Air Force has a number of bases in our area, (F.E. Warren AFB, Cheyenne, Wyoming; Ellsworth Air Force Base, Rapid City, South Dakota; Malmstrom Air Force Base, Helena, Montana) there are no routine flights between these bases despite the fact that the military has major medical installations in both the Denver and Colorado Springs areas. (See Attachment A.) Consequently, the only alternative open to us is diverting an Air-Evac plane. In this case, we cannot guarantee that the plane will arrive on schedule since the current agreement allows them to divert the plane for higher priorities without notice. Moreover, the Air Force Air-Evac system will not, at the current time, routinely utilize the Cheyenne airport facilities even though F.E. Warren AFB, a major installation, is located in the Cheyenne area. Consequently, as is the case with private airlines, our patients must be transported to the Denver area to meet the Air Evac planes. As I noted in my testimony, this is a distance of approximately 120 miles.

Question: 3. If so, is such an agreement in effect? If no such agreement or practice is in effect, what are the obstacles to such an arrangement being reached?

Answer: Despite the fact that there are major Air Force installations throughout our area, and the fact that there are major military medical installations in the Denver and Colorado Springs area, there is no routine Air Force route in servicing the area north of Denver. Despite this traffic volume and the additional volume that could be provided by the VA facilities in this area, to the best of our knowledge, there is no desire on the part of the Air Force to establish routes that would be convenient and available to us.

In addition to the Air Force, it might be possible to look to the Wyoming Air National Guard to provide assistance since their major base of operations is in the Cheyenne area. However, it is our understanding that current law prevents them from providing this type of assistance except in emergency situations despite the fact that no commercial airline provides services between Sheridan and Cheyenne.

Question: 4. Is there a need in Wyoming for additional outpatient/outreach clinic services for veterans?

Answer: Yes.

Question: 5. How do you measure that need?

Answer: As I indicated in my testimony, in FY 1988, 84% of our total annual outpatient visits came from the ten counties in Wyoming, eastern Nebraska and Colorado that are within 100 miles of Cheyenne. The remaining twelve counties in our primary service area, including Natrona County home of Casper, our second largest city, are over 150 miles from Cheyenne and Sheridan and only accounted for 16% of our visits. There is no reason to believe that the veterans' demographics in these outlying areas are any different than in the counties closer to the Cheyenne VA Center. The only difference is the distance that they are from the Cheyenne VA Center. Consequently, we would expect, if there was a VA facility within 100 miles, they would choose to utilize it just as those who are now within 100 miles of the Cheyenne VA Center currently do.

Current studies indicate that the utilization of VA outpatient facilities declines rapidly when veterans must travel over 100 miles each way. As I just noted, our statistics for FY 1988 agree with these studies.

Question: 6. What type(s) of outpatient/outreach services are now available to veterans in Wyoming?

Answer: Currently, the Cheyenne VA Center operates a monthly clinic in Torrington, Wyoming, which is approximately 84 miles from the Cheyenne VA Center. This clinic consists of a Nurse Practitioner who drives to Torrington once every month. This service has not been very cost-effective because of the limited service that this one nurse can provide and the fact that most of her time is consumed in driving to and from Torrington.

In addition, there is a Vet Center in the Casper area. However, this particular Vet Center does not provide any type of medical care or treatment.

Question: 7. Where are these services available?

Answer: See answer to Question 6.

Question: 8. Do you plan to implement additional services?

Answer: Since Fiscal Year 1987, the Cheyenne VA Center has had a Medical District Initiated Plan (MEDIPP) approved to establish an Outreach Clinic in the Casper, Wyoming area. Because of insufficiency of MEDIPP planning funds, this clinic has not been implemented.

Since the development of the plan to implement a Casper Outreach Clinic, we have again reviewed the need for outreach services in Wyoming and have determined that the implementation of two additional Outreach Clinics, one in Scottsbluff and one in the Riverton-Lander areas, would bring VA care to within 100 miles to all veterans in our primary service area. More importantly, each of these areas would have sufficient number of veterans to justify their cost.

Question: 9. If so, what type of outpatient/outreach services do you plan, or what would, in your opinion, be the most efficient and effective service?

Answer: As I noted previously, our study of the rural health needs of veterans in our Wyoming, eastern Nebraska area indicates that the establishment of three small rural community-based clinics located in Casper, Wyoming, Scottsbluff, Nebraska and the Riverton-Lander, Wyoming areas would be cost-effective. As designed, these clinics would be established in juxtaposition with existing health care facilities such as the Family Practice Residency Program in Casper and the State Veterans Home in Scottsbluff.

These three community-based clinics would provide basic general medical care to veterans, conduct various types of clinics such as hypertension, diabetes, anti-coagulation and, should appropriate health workers be available, provide basic psychosocial therapy. In addition, the clinics would identify the needs for more advanced medical-surgical treatment and refer patients, when necessary, back to Cheyenne for specialty care. Finally, once a treatment regime had been determined by the specialty clinics in Cheyenne or at other VA tertiary care hospitals, the clinics would provide, within their capabilities, the follow-up treatment for the patients. In this case, however, the patient travel would be greatly reduced.

It is anticipated that radiological procedures would be contracted for on-site and laboratory and pharmaceutical services, with the exception of basic tests and emergency procedures, would be provided by the Cheyenne VAM&ROC. The results of these tests would then be transmitted via telecommunications links.

Question: 10. Who would be served by such an arrangement?

Answer: It is anticipated that the Casper Clinic would provide basic general medical-surgical services to the 13,527 veterans in Natrona, Converse and Carbon Counties. The Scottsbluff Clinic would provide care for the approximately 9,000 veterans in Scottsbluff, Banner, Kimball, Morrill, Cheyenne and Keith Counties in Nebraska and Goshen County in Wyoming. Finally, it is anticipated that the Riverton-Lander Clinic would provide care to the 5,709 veterans in Fremont, Hot Springs and Washakie Counties.

As is the case in Cheyenne currently, not all veterans will choose to use the VA facilities or be eligible to use VA facilities because of their service-connected or income status. In this latter case, it would be our intent to apply the same criteria to these clinics that are being applied at the Cheyenne VA. Consequently, all veterans in our PSA would be treated exactly the same.

Question: What type of staffing would be required, and what would its estimated start-up and annual cost be?

Answer: As currently planned, the three satellite Outpatient Clinics would require a total of approximately 14 FTEE on an annual basis. Depending on what type of sharing arrangements can be negotiated with existing facilities in the three areas, it is estimated that the annual operating cost in FY 89 for all three clinics would be approximately $1,400,000, with an additional $253,000 needed in the first year for non-recurring start up costs such as furniture and telecommunication equipment.

Individually, the following estimated costs would be associated with each individual clinic:

	Casper	Lander	Scottsbluff
Est. Salary Exp:	$291,336	$291,336	$291,336
Est. Operat. Exp:	248,872	117,991	148,261
	540,208	409,327	439,597
Est. Start-Up	84,343	84,343	84,343

Question: 12. Would an outpatient/outreach clinic located in Casper affect the patient load in Cheyenne and Sheridan?

Answer: As I noted in my testimony, 84% of the total annual outpatient visits at the Cheyenne VA Center came from ten counties in Wyoming, eastern Nebraska and Colorado, which are within 100 miles. The remaining 12 counties, including Natrona County which is the home of Casper, have only accounted for 16% of our visits. Because of this, we would anticipate that these Outreach Clinics would not only generate additional visits at their own site but would also generate additional visits at the Cheyenne and Sheridan VA Centers. These additional visits at the Cheyenne and Sheridan VA Centers would be generated because the clinics are essentially general medical clinics and would be identifying needs for additional surgical and specialty care available only at the Sheridan and Cheyenne VA Centers. Moreover, it is expected that treatment on an outpatient basis would generate a need for inpatient treatment periodically. Since the veteran populations to be served by these clinics currently have a very low utilization of our existing inpatient facilities. We expect that the outreach clinics will generate additional inpatient workload which both the Cheyenne and Sheridan VA Centers can handle.

Question: 13. In recent years, Congress has created new entitlements to VA health care and has written different rules for outpatient care and inpatient care. Has this created difficulties for the medical centers in administration, and have veterans encountered difficulties as a result of the new rules?

Answer: Yes. As I indicated in my testimony, because of the financial problems faced by the Center in FY 89, we were forced to restrict our care to only those veterans who had mandatory entitlement to VA treatment. Consequently, we restricted eligibility only to those veterans who were Category A eligible for inpatient care and for outpatient care to those veterans who were receiving treatment for their service-connected injuries; with service-connected over 30%; or were veterans, service-connected or nonservice-connected whose annual income was less than $10,338.

The inpatient eligibility guidelines are relatively simple to explain. They are based essentially on service-connected status and one, easily understood, income criteria. The outpatient eligibility criteria, on the other hand, are highly technical; are based on portions of service-connection and income criteria which is different from the inpatient criteria. Trying to explain to an elderly veteran who is 20% service-connected for a gunshot wound that he is entitled to inpatient care but not to outpatient care for treatment of his heart condition is extremely difficult. Not only is it difficult for the veteran to understand but it is indeed difficult for our employees to understand.

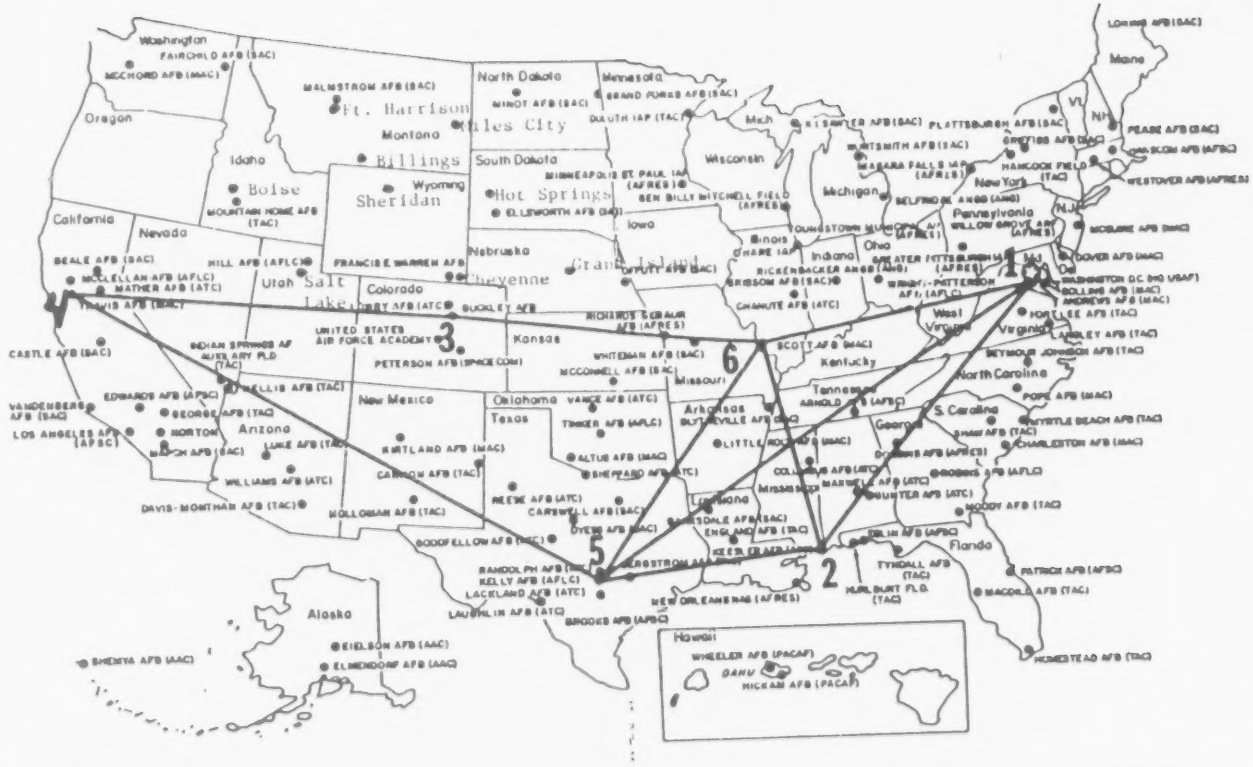
Moreover, the more generous inpatient eligibility criteria essentially encouraged more expensive inpatient treatment. Ironically, at a time of great fiscal constraints, the eligibility laws were encouraging more expensive forms of treatment.

Question: 14. Do you have any way of measuring whether there are veterans who are seeking care in Wyoming and who are not getting that care, even though they may be entitled to care under the law?

Answer: The current law essentially makes a distinction between mandatory and non-mandatory entitlements. Every veteran who is discharged with other than a dishonorable discharge is entitled to health care based upon the local availability of resources. Of this total group, a certain group based upon their service-connected status and their income level, is mandatorily entitled to health care services. That is to say, they cannot be turned away if they apply.

No veteran who is mandatorily entitled to care has been turned away. Moreover, no veteran who had emergent need for medical care, regardless of whether or not he is mandatorily eligible for care, has been turned away. However, last fiscal year because of our fiscal problems at the Cheyenne VA Center, 651 non-mandatorily entitled veterans were discharged from care at the Cheyenne VA Center. Similarly, at the Sheridan VA Center a number of veterans who were non-mandatorily entitled to health care, were discharged from treatment.

However, as I noted in my testimony, and earlier in the responses to these questions, at the present time 84% of our outpatient visits came from only half of the counties in our PSA. If we assume that the distribution of mandatorily entitled veterans is essentially the same in every county in Wyoming and eastern Nebraska, it is also reasonable to assume that a number of mandatorily entitled veterans did not apply for health care because of the distance they would have to travel to either Sheridan or Cheyenne. At the present time, we have no exact way of counting this but we know that it exists. Three satellite outreach clinics will cost-effectively assure that choice and distance will not be the determining factor for whether or not an eligible veteran applies for health care.



KEY TO SCHEDULED FLIGHTS (C9's)

1 ANDREWS	1 TO 2	MON THU	2 TO 1	WED SUN	4 TO 1	THU SUN	5 TO 2	FRI	6 TO 1	MON WED THU FRI SAT SUN
2 KEESLER	1 TO 4	THU SAT	2 TO 5	WED SAT	4 TO 3	FRI	5 TO 4	MON WED	6 TO 2	MON TUE WED FRI SUN
3 BUCKLEY	1 TO 6	MON	3 TO 4	WED SAT	4 TO 5	TUE	5 TO 6	TUE	6 TO 3	MON TUE WED THU FRI SAT
4 TRAVIS		WED	3 TO 6	TUE THU FRI	4 TO 6	TUE		WED	6 TO 4	MON WED THU SAT
5 KELLY		THU				THU		FRI	6 TO 5	MON TUE WED THU SAT
6 SCOTT		SAT				FRI		SAT		
		SUN				SUN		SUN		